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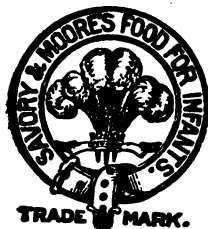
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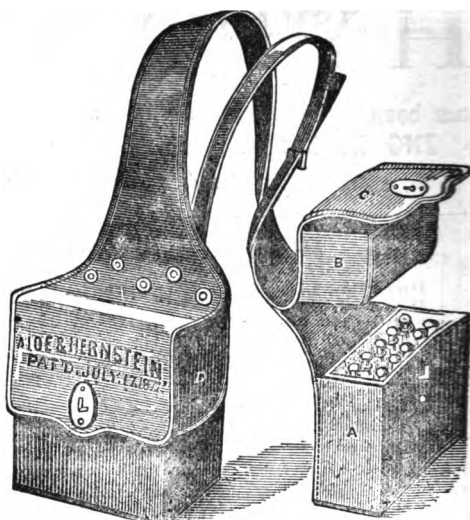
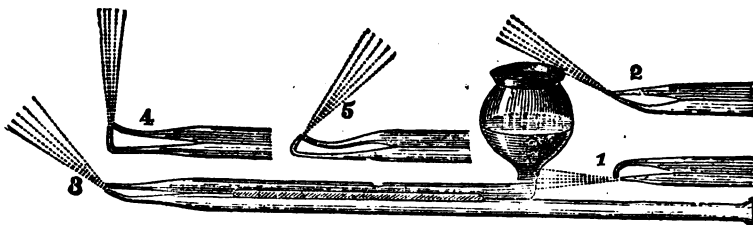
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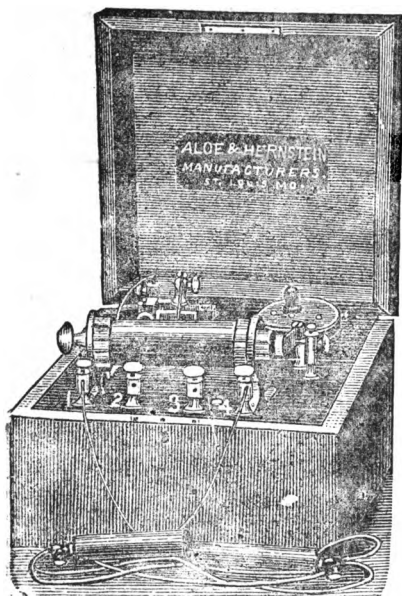
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VOL. LXII.

—JANUARY 1882.—

No. I.

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Original Contributions.

ARTICLE I.

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NOTES OF CASES IN GENITO-URINARY SURGERY.

—CASE No. IV.—

STRICTURES OF LARGE CALIBRE OF THE PERINEAL AND PENILE URETHRA.—OBSTINATE PROSTATO-CYSTITIS.—INTERNAL URETHROTOMY, FOLLOWED BY BLADDER-WASHINGS AND INJECTION OF STRONG NITRATE OF SILVER SOLUTIONS INTO THE BLADDER. By W. HUTSON FORD, M. D. of St. Louis.

July 26, 1880. Mr. E. S.—Aet. 32: book-keeper; bachelor; eight or ten years ago had Syphilis, but has long ceased to feel any effects from it. Preputial orifice consists in a hypospadiatic opening just where the frænum is attached to the prepuce. He is circumcised, (Hebrew nationality). Gonorrhœa ten years since, and again some four years ago. Circumference of penis, three inches. Suffers from frequent dull pains in the back, referred to the renal region. Bowels disposed to constipation. After retiring at 10 or 11 P. M., sleeps tolerably well until 4 or 5 A. M., when he is obliged to rise and pass water. During the

day micturition is abnormally frequent, about once every hour. Occasional temporal and frontal headaches. Discolored cicatricial patches on the anterior aspect of the legs attest his syphilis of some years back. His general appearance indicates confirmed chronic disease, and his face is worn and haggard. There is no pain after or during micturition. Pulse 80. Tongue furred. Has never passed any blood by the urethra or anus.

July 27. 9 P. M. Urinates before me; the stream is of moderate size; some hesitation of the bladder; urine pale, sp. gr. 1022. or slightly alkaline. Distinctly ammoniacal. Full of mucus.

July 28. Examined for stone with Mercier's No Stone. sound. No stone. Bladder very little sensitive, not fasciculated.

Aug. 1. Bladder has been washed out twice a day with Borax and Hyposulphite of Soda. The bulb is strongly contracted to 22 F. Whether this constriction is organic or spasmodic cannot yet be said positively.

This morning the orifice of the hypospadiatic urethra was enlarged to 33, by *lateral incisions*. B. B. 33 passed down an inch or so; beyond this, 29 only would pass. Bladder washed out twice daily with distilled water.

Aug. 2. B. B. 33 passed down one inch. bladder washings continued.

Aug. 3. c. s. 26 with some difficulty through the bulb. Urine is now perfectly free from odor.

Aug. 4. B. B. 23 with difficulty through bulb. There is a series of irregular contractions of not less than 28 beginning just behind the scrotum, and extending to an inch behind the glans; the bulbous region is quite free from stricture.

The urine is alkaline, slightly cloudy, depositing fragments of mucus, but not strings. It is almost devoid of odor. He continues to take Bethesda Water and Benzoate of Soda and alkali. Advised section of the stricture by internal urethrotomy.

Aug. 5. Cholagogue pill to-night. Quinine grs. v. four times a day.

Aug. 6. B. B. 33 down one inch. Urine much better colored. c. s. 36 went through bulb with moderate facility.

Aug. 7. Urine still improved; fairly acid.

Aug. 8. Urine clearer of shreds and mucus. Passed water yesterday but once in two or three hours. The pain in the loins is decidedly abated. Urine perfectly free from odor. Com-

plexion clearer. Tongue still coated, but much less so than formerly.

Aug. 10. Bladder regularly washed out twice a day with distilled water containing five or six drachms of a solution of borax and hyposulphite of soda in its last four ounces.

c. s. 29 passed easily but with pain at orifice.

Aug. 11. Bladder washed out twice to-day. Will divide the strictured bands in front of the bulb to-morrow.

Aug. 13, 11 A. M. Internal urethrotomy with Otis' dilating urethrotome. Dr. Wm. Webb assisting. B. B. 27 passed bulb with difficulty. B. B. 29 defined contraction in the perineal urethra, also one in the scrotal region and also one an inch down. B. B. 33 could not enter the meatus. Æther administered. The strictures divided to 36. The hypospadiatic meatus also extended on each side by incisions close to the corpora cavernosa. B. B. 33 passed readily to bulb. c. s. 33 passed easily into the bladder. But little hemorrhage. Cold applications. Quinine, recumbency.

Deep Internal Urethrotomy.

3:30 P. M. Had a chill of some half an hour's duration about 1 P. M., after making water for the second time; also some bleeding. Vomited. Applied the perineal tourniquet, and splinted the penis. Veratrum and quinine. Absolute diet.

8 P. M. No further chill. Temperature and pulse normal. Quinine every four hours. v. v. at 9, 12, 4 and 7 A. M. Has not bled. Morphine grs.  $\frac{1}{4}$  at 9:30 to-night.

Aug. 14, 10 A. M. Doing finely. No hemorrhage. Pulse 56. Temperature normal. The tourniquet is well borne. Vomited last night, probably under the influence of the veratrum. Ordered quinine grs. v. every three hours. v. v. gtt. v. at 12 and 4 P. M.

Aug. 15. No hemorrhage. Doing finely. Quinine and alkaline diuretic. Vichy water. Urine is red and highly acid.

Aug. 16. Doing well. Continue all medicines. Milk-toast. Soup.

Aug. 17. Doing well; c. s. 31. passed easily.

c. s. 34 immediately afterwards passed clearly through the bulbar and membranous urethra without any difficulty. No bleeding. Has had no fever nor chill.

Ordered diluents and soda; continues Quinine three times a day.

Sounds 31 and 34 on the Fourth Day.

Aug. 19. No chill, hemorrhage nor fever. Tongue a little

coated. Cholagogue pill to-day, and also to-night. Continues quinine in reduced doses, and the alkaline diuretic.

Evening, 8 p. m. He complains of some pain on the right side of the neck, or the "posterior triangular space," where a diffused swelling is barely perceptible, and some tenderness on pressure exists. This area was painted with Churchill's tinct. of iodine. He also complains of constant pain in the head. The quinine is intermitted for to-night. Temperature and pulse normal. The weather is excessively hot.

Aug. 20. The headache is better this morning. The swelling noted yesterday has existed for several weeks. The urine is very pungent, red and somewhat ammoniacal. Bladder washed out with warm water containing borax mixture. Castor oil.

Evening, 8 p. m. Oil has acted. Bladder washed out. Temperature 100°, pulse 84. Ordered veratrum gtt. v. at 10, 2 and 7 A. M.

Aug. 21. Better. c. s. 33 and 84 passed. Bladder washed out.

Aug. 22. Bladder washed out night and morning. The bilious condition is so marked this evening that an emetic is prescribed of ipecac and tartarized antimony 3j to grs. j. in ch. iv. This to be followed by a cholagogue pill at 10 p. m., and Ol. Ricini in morning.

Inter-  
current  
Bilious  
Attack.

Aug. 22. The tongue is much coated and slimy. Pains in the renal regions. Bladder not washed out. Temperature 100½°. Pulse 84. Ordered counter irritation (Sinapisms) to the back. Alkaline diuretic. The oil acted two or three times. Milk and lime water only.

8 p. m. Ordered grs. vi. Bisulphate of quinine every four hours. It is evidently a malarial complication. Bladder washed out.

Aug. 24. Somewhat better. Temperature 99.5. Pulse 80. Terminal stricture dilated to 33. Allowed a few fresh oysters and some buttermilk.

8 30: p. m. Sleepy. Sweating heavily. Pulse and temperature normal. Ordered grs. vi. quinine at 9 p. m., at 2 A. M. and 8 A. M.

Aug. 25. Better. Urine more natural. Continues quinine. Saline Laxative. Diet.

Aug. 26. 8 p. m. Salts has acted well. Altogether better to-night. Bladder washed. Quinine grs. vi. at bed-time, and at 7 A. M. to-morrow.



Aug. 27. Sounds 33 passed bulb. 34 down to bulb. Is much better. Bladder washed out once a day. Quinine continued.

Sounds  
Passed.

Aug. 28. Better. The urine is still pungent and somewhat muddy. Will make an injection of nitrate of silver this evening.

Injection of  
Nitrate of  
Silver.

7:30 P. M. Doing very well but weak. Two ounces of a ten grain solution of nitrate of silver injected into the bladder. Hot water controlled the pain, which was moderate.

Aug. 29. Sitting up. Some increase in frequency of micturition last night. Pain lasted altogether until 3 A. M. Is better this morning. Tongue clearing.

7:30 P. M. Urinated five times since-morning; a few drops of blood passed towards the end of micturition, each time except the last. Ordered Hot Sitz-bath, Diluents and Sod. Continue quinine grs. vi. twice a day.

Temporary  
Exaltation  
of the Cys-  
titis.

Aug. 30, 10 A. M. No more blood upon urination, but an increase of the mucus in the urine, and of the frequency of micturition. Continue recumbency. Castor oil.

7:30, P. M. Oil has acted. The urine looks better. Ordered a suppository of morphine and belladonna at bed-time.

Aug. 31. Better. Urine looks clearer. c. s. 32 and 34 passed. Is to wash out the bladder once a day. Diluents and Sod. Iron tonic.

Sounds  
Passed.

Sept. 2. Calls on me looking much clearer. Urine without odor and greatly improved. Bladder washed every morning.

Sept. 4, 10 A. M. c. s. 33 and 34 passed. The urine looks better. He leaves by my advice for Waukesha, Wis. this evening. Ordered to wash the bladder every day.

Sounds  
passed.

Sept. 13. Returned much improved. Urine very nearly normal and neutral. c. s. 33 passed. Will have a course of sounds every other day for some remaining prostatic tenderness and pain in the back.

Improve-  
ment.

Jan., 1881. His urinary troubles have all disappeared. He has gained astonishingly in weight and appearance. His complexion is now of good color, and he states that his health is very good indeed.

Complete  
Recovery.

ARTICLE II.

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THE HISTO-PATHOLOGY OF SCARLET FEVER.\* By Dr. G. V. BLACK,  
of Jacksonville, Ills.

[ Concluded. ]

We will now examine the evidences that the affection extends also to the alimentary epithelium. Thomas says very truly that "the process has not ended when the eruption pales. Other disturbances which have arisen during the inflammation of the superficial cutaneous layers, must run their course. These result in an excessive formation of new epidermis which is followed by an abundant exfoliation." If this result be found in the alimentary tract, we have good reason for believing that processes similar to those of the skin have been in operation. Those dying in the midst of the rash do not show a rash upon the mucous membranes of the alimentary tract; nor do they on the skin for in a very short time after death, the surface pales, all appearance of the rash is gone, and we suppose the same thing to occur on the mucus membranes, as may actually be seen in the mouth and throat. Thomas says that by injecting with a colored fluid, a picture of the exanthem very similar to that in life may be reproduced. Here we have a very peculiar proof that the inflammation is only of the epithelium, and that the blood vessels are not involved. There is no stasis as in ordinary inflammations, and after death the expanded vessels, though empty and collapsed, are easily refilled by injection, reproducing the rash. Now, by these various means, we find that observers have furnished the facts which show that the exanthem is not confined to the squamous epithelium, but that the columnar epithelium of the alimentary tract is very generally, if not always involved. It may be that the involvement of this epithelium is in most Scarlet Fever epidemics, very slight, perhaps not sufficient in the majority of cases, to give serious trouble; yet in individual cases, and in some epidemics this is a serious feature of the disease. Very serious cases occur with but very slight, or no rash upon the skin. Several observers, Fenwic, Hilier, Niemeyer and others, have found the gastric tubules filled and distended

with fatty, and granular, and epithelial casts, the same casts in the contents of the stomach, also, casts of the tubal glands of the small and large intestines have been found in these cavities.

So prominent did Dr. John Harley of London, find the intestinal lesions in an epidemic of Scarlet Fever, that he considered there was a close resemblance between this disease and enteric fever, so close indeed, that he seems to have considered the first stages of the two diseases identical. It is almost certain that in those cases of scarlet fever ending in sudden death, without the appearance of the rash, we have a very severe epithelial inflammation either in the alimentary tract, or in the kidneys, or in both. The dangerous character which the disease assumes when the kidneys are involved, is well known. Niemeyer states that he has in almost all cases, found the affection of the kidneys to be as intense as that of the skin, and of the same character. We have abundant evidence, however, that there is a wide difference in the different epidemics as to the severity of the inflammation in the several localities. For instance, one epidemic may furnish the anginous variety; in another the kidneys may be prominently affected; while in a third, the inflammation may be confined almost exclusively to the skin. There is, however, an evident error in the minds of many physicians in regard to the nature of the kidney affection. It seems to be regarded rather as a complication, when in fact it is an intrinsic factor, and not a mere accidental complication of the disease.

The fact that in many cases it is not a grave feature of the disease, by no means makes it an accident of the affection. It is almost always present, though often mild. And there is good reason to think that it figures more largely in the early part of the affection, than is generally believed. In many a patient, who when attacked, passes rapidly into convulsion and coma, and quickly dies, the failure of the kidneys is unmistakably the underlying cause. Early in the disease, the stage of eruption, when the epithelial inflammation is in progress in the kidneys, if the process be mild, these organs still perform their functions; the urea is excreted, and no great difficulty is experienced, but when the inflammation is so severe as to interfere with their functions, the worst results follow. Autopsies in these cases, reveal the profound disturbances of the epithelial elements of the tubules. Not only in those cases in which the disease has reached the stage of desquamation, but during the stage of erup-

tion. Here, says Thomas, "The cortical substance is particularly the seat of changes, the morbid process begins in the Malpighian bodies, and then follows the course of the convoluted tubules." This description expresses the exact counterpart of what we have described, as occurring in the sweat glands. Traube found a rapid proliferation of the cells of the tubules throughout their entire length, and that these cells undergo an albuminous degeneration. E. Wagner describes the epithelial cells of the tubules as clouded, enlarged, changed in position, or even entirely destroyed; or frequently pushed off so that the tubules which besides them, contain white and red blood corpuscles, as well as various quantities of cylinder shaped exudation masses, were sometimes completely blocked up. These disturbances in an organ constituted as the kidneys, are of the gravest character; the entire organ becomes hyperæmic and distended with blood, and a more or less intense inflammatory process is set up in the general substance of the organ, resulting in the rapid proliferation of connective tissue elements between the tubules, especially masses of fusiform cells which in the worst cases, undergo speedy albuminoid or fatty degeneration.

These changes interfere with the function of the glands in direct ratio with their severity. If the inflammatory process be mild in the epithelial cells, we will have but a passing hyperæmia with no marked functional disturbance. The urine will show some albumen and an unusual abundance of renal epithelium, some exudation globules, and a few blood disks, all of which will pass away in a few days without producing any especial symptoms. We think the rule is, that inflammation of the kidneys give rise to no pain referred to the region of these glands. Patients die of uræmia, who have never complained of pain.

It is, however, in the later stages of scarlet fever, during the period of desquamation that we usually see the most disastrous effects upon the kidneys. This is a different affection, arising from a different cause. It is properly a resultant or secondary affection dependent upon the peculiar anatomy of the organ. brought about in a mechanical way during the desquamation of the epithelium of the tubuli uriniferi. If the desquamation be abundant, the long and tortuous tubules are unable to free themselves of the accumulations of cast-off cells, and become blocked up. This in turn gives rise to an inflammation due merely to this mechanical cause which is not specially epithelial, though

during its continuance it prevents epithelial repair. Here now, we have an ordinary simple inflammation with fibrinous deposits in connection with an over abundant epithelial desquamation; hence, we have the cast off cells glued together in the form of casts of the tubules, giving farther hindrance to their exit. To add to the difficulty, the whole organ becomes distended with blood in proportion to the intensity of the inflammatory process. This tends to compress the tubules, and render it still more difficult for them to rid themselves of their abnormal contents.

Let us try to illustrate: Suppose we take a membranous sack, and into it we pass three rubber tubes representing an artery, a vein and a tubule of the kidney. The one representing the tubule is wound about several times within the sack, and its inner end is stopped with a bit of sponge through which a fluid can percolate representing a Malpighian corpuscle. Now, suppose we fill the sack with fluid by the tube representing the artery, and allow it to escape by the tube representing the vein. A portion of the fluid will percolate through the sponge representing the Malpighian corpuscle and escape by the representative of the tubule. Now it will readily be seen that if the pressure of the fluid within the sack be raised to a certain point, the tube representing the tubule will be collapsed, preventing the escape of the fluid by that route, and if an obstruction be placed within it, anywhere along its course within the sack, the walls of the tube will be compressed upon it, and prevent its passage along the tube. The best conditions for the exit of this obstruction, will be a comparatively low pressure of the liquid within the sack, allowing the fullest expansion of the tube.

This is the type of the conditions present in the kidney, in the secondary inflammation of scarlet fever. An irritation is first caused by the obstruction of the tubules by the cast-off epithelium. Then, according to the general law of irritation and inflammation, a greater amount of blood is called to the part. The kidney becomes hyperæmic and swollen, thus compressing the tubules which are already struggling to free themselves of their epithelial obstructions. What shall be done in this condition? The history of scarlet fever shows that thousands of children die as the result of this renal congestion. The one thing to do, is to lessen this blood pressure; and this should be done at once, and most thoroughly. It matters not just how it be effected, so it is done, and done at once. For this purpose, *veratrum viride*

given until the heart's action is reduced to the lowest limit compatible with safety, has proved itself more prompt, efficient and safe than any other agent. This effect should be maintained until the tubules have freed themselves from their obstructions which they will usually do in a few days, and the difficulty which threatened a speedy death, is ended.

Inquiry into the condition of the other thelia, is important. In reference to the pavement or serus endothelium, and the endothelium of the blood vascular system, we have seen no report whatever, except that they are found healthy, which would undoubtedly be the gross appearance. As yet we have read no author who reported having critically examined these structures to determine whether or not the characteristic changes could also be found there. The fact that these thelia are widely separated from the squamous and alimentary in both their origin and function, and no affection of them having been noticed, would seem to indicate their complete exemption. Yet the very profound disturbance of the circulation in this disease holds out a suspicion that they may be involved. Special examinations in this direction are certainly to be desired.

Of the respiratory epithelium, we have more definite information. The question, of whether or not the inflammation of the throat extends into the air passages without the presence of true diphtheria or croup, is one which has been much discussed. Without entering this field of discussion, we can easily glean from the abundant writings, the facts as to the order of the involvement of these structures. The evidence is satisfactory that the respiratory epithelium is exempt in scarlet fever, except at, and extensions from, those points where it comes in contact with the squamous epithelium. At these points, it will be remembered, there is more or less change in the type of each of the thelia as they approach each other, constituting as it were, an intermediate type. Notwithstanding this, the scarlatinous process appears not to cross the lines so readily as would be supposed, and in a very large proportion of cases, the inflammation extends just to this line, and no farther. But if the inflammation be very severe, or the sub-epithelial structures become involved, then the inflammation passes over to the respiratory epithelium. When this epithelium does become involved, the nature of the changes which take place, differ in character from those occurring in the squamous variety, in that the tendency is to the rapid destruction

of large portions of the epithelial covering, and inflammation and suppuration of the sub-thelial structures. The point of crossing is almost always over the border of the soft palate, or in the pharynx, with rapid extension from behind forward, usually involving both the posterior and anterior nares in a very destructive inflammation, which in severe cases, destroys large portions of the columnar ciliated epithelium and gives rise to an ichorous pus. It thus leaves a surface denuded of its epithelial covering which heals with difficulty, and is prone to leave permanent nasal catarrh.

The large number of cases of the loss of hearing which results from scarlet fever, leads us to say a few words on that point: The Eustachian tubes and the greater part of the tympanic cavity, are lined with the respiratory epithelium, and it is undoubtedly by extension of the inflammation along the tube, that the ear becomes involved, which not only threatens the loss of hearing, but is a point of danger to the life of the patient. When the dividing line is once crossed, and the respiratory epithelium becomes involved, the invasion of the Eustachian tube, readily occurs and the inflammatory process advances to the middle ear, setting up an ulcerative process with the formation of pus. The swollen condition of the Eustachian tube has shut the door of exit, and the pus is retained in the tympanic cavity, and by pressure causes a general inflammation of the middle ear; the drum becomes bulged, and finally yields to the pressure of the pent up pus which finds an outlet through the external meatus. But it sometimes happens that the pus finds an exit through the very thin partitions into the brain, causing the death of the patient. For these reasons it is important that the practitioner should be provided with the Otoscope and puncturing lance; and that he examine frequently and carefully the membrana tympani in all suspected cases, and whenever the membrane is found bulging, paracentesis should be at once performed. Such a course will not only save life occasionally, but will relieve suffering and diminish the number of pupils in our institutions for the education of deaf mutes. The crossing of the line at the glottis is of much more rare occurrence, but when it does occur, it is characterized by the same destructive inflammatory process as is seen in the nares. Now, as to whether this involvement of the respiratory epithelium and the subepithelial structures should be regarded as a diphtheritic complication.



is a question we will not now discuss. The point has been discussed at length, both in the text books and journals, without resulting in any uniformity of opinion among medical men.

When the subject is viewed from a Histo-pathological standpoint, the lungs must be looked upon as tubular glands. Their formation is effected in the same manner as other glands. There is a differentiation of its epithelium which separates it widely, both histologically and physiologically from the epithelium from which it was originally derived. Hence, its involvement in scarlet fever, is a result of contiguity rather than any special affinity of the disease for it.

The involvement of the tonsils, and post-lingual glands, or follicles, is a point of much interest, as being the most common point from which serious inflammatory lesions arise; and as it seems to me, often determines the involvement of the respiratory epithelium, by first communicating the morbid process to the connective tissue. We must examine for a moment, the compound character of these glands. Around the dorsum of the root of the tongue there is a multitude of small tubal glands, with quite narrow ducts, which dip down into the sub-epithelial tissues. Their lining is an indipping of the rete Malpighii. Each of these little tubes has in immediate juxtaposition with its membrana propria a setting of minute lymphatic glands, entirely surrounding it. The structure of the tonsils is much the same, but here the glands are much more voluminous. These lymphatics present a striking likeness to Pyers' patches in the small intestines, and according to the statements of various authors, not unfrequently ulcerate in typhoid fever. Now it seems that when the epithelial inflammation is severe in this locality, it is communicated to the lymphatics surrounding these tubes, both on the root of the tongue, and in the tonsils. These become swollen rapidly, and are very likely to ulcerate, and extension of the morbid process to the adjacent connective tissue, and through the medium of the lymphatics is the result. This gives rise to what is known as the anginous variety of the disease which is always to be dreaded on account of the swelling and ulceration of the lymphatic glands about the throat and neck. The lymphatics are especially liable to secondary inflammations from the nature of their function, and their relations to the epithelium at this point increases that liability. The contiguity of the parotid glands to those lymphatics most liable to inflammation, has given

rise to the opinion that they are especially liable to attack. This, however, is an evident error. Considering the amount of inflammation in their immediate neighborhood, it is not surprising that they should occasionally become involved; but post mortems generally show that they have escaped. The comparative freedom of these glands together with all other lobular glands, the clinical history of the disease and post mortem examinations, seem to prove beyond question. This is somewhat surprising when we consider their origin, and the derivation of their epithelium directly from the muco-squamous, which is usually so profoundly affected. However, we must remember that the epithelium of all lobular glands is very profoundly modified both in form and function. So far as we are able to discern, the lobular glands throughout the body are no more affected in this, than in other severe fevers. On the other hand, the tubal glands formed from either the squamous or alimentary thelia are involved as uniformly as the thelia from which they are derived.

**THE FEVER** in scarlatina is especially intense, and constitutes a leading characteristic of the disease. This does not always seem to correspond with the intensity of the rash on the skin, but as we have remarked, it seems to be closely related to it. The severity of the epithelial inflammation may be in the alimentary canal, or in the kidneys, and not be apparent; or it may be confined to the glomerules of the sweat glands, and escape prominence. The sweat glands, it must be remembered, have as one of their functions, the elimination of superfluous heat from the body; hence, their greater activity when we become heated in warm weather, or in unusual physical exercise. This is one basis from which we may do something toward accounting for the great increase of temperature. Another is the serious nature of the lesions, involving as they do, such large tracts of tissue. When we think of the involvement of the entire surface of the body, the alimentary tract and urinary system in an inflammation of their functional tissue, we should not be surprised at grave constitutional disturbances. What the effect of the scarlatinous poison may be upon the blood itself, we have no positive data for determining. It does not seem to differ from the condition found in other affections characterized by great heat, and therefore does not offer, so far as is yet discovered, any peculiarities attributable to the direct effects of a blood poison.

The great elevation of temperature accompanying scarlet fever, is one of the chief sources of danger. There seems to be but little doubt that death often occurs directly from sun-stroke, or as a result of over heat upon the nerve centers. There are no typical lesions of the nervous system in this disease. Authors who have made extensive post mortem examinations, agree that the nervous structures are found healthy, with the exception of occasional slight congestions. Yet, severe nervous phenomena are of frequent occurrence; we therefore conclude that these are due to the intensity of the heat coupled with the extreme arterial excitement. This however, is sometimes due to uræmia. Indeed, we are inclined to the opinion that this is much oftener the case than is generally thought, by writers on this subject. This opinion is based upon the results of post mortem examinations, and upon the clinical history of the disease in its acute stages.

Scarlet fever often leaves characteristic markings upon the teeth. The enamel of the teeth is derived from an ingrowth and differentiation of the rete Malpighii of the muco-squamous epithelium of the mouth. If the fever occurs while the enamel is forming upon any particular teeth, a mark is often left encircling them at a point where the cells, then at a certain stage of growth, have been destroyed or imperfectly developed. Suppose the line to run around the middle of the central incisors, it will be nearer the cutting edge of the laterals, and perhaps just touch the points of the cuspids. In other cases it will mark the first molars alone, perhaps robbing them of their cusps. The enamel begins its formation in these first of all the permanent teeth. If the disease has occurred later, the line may be seen crossing the bicuspidis disappearing under the gums as it approaches the front of the mouth. Later still, the second molars alone will be marked. This effect upon the teeth is not constant and furnishes no indication as to the severity of the disease in the individual case, giving another indication of the habit of the disease of spending its force, sometimes in one place, and again in another.

In conclusion we may sum up, by saying that scarlet fever is a contagious, epidemic disease, communicated and propagated by a specific poison; the first effects of which are seen upon the constitution at large, acting probably through the medium of the blood. The characteristic lesions of the disease, are found in the squamous epithelium of the skin, and the columnar epithe-

lium of the alimentary tract, and in their glandular derivatives which have been least changed in form and function; which consist of the tubal glands, the sweat glands, the tonsils and the post lingual glands derived from the squamous variety. The follicles of the stomach, the Lieberkühnean glands of the intestine from the columnar, and the kidneys, which are probably derived from the columnar also.

When the inflammatory process passes from the tissue of its election, it is usually found to be to the respiratory epithelium in the pharynx and larynx; and to the lymphatics, and thence, to the connective tissue in the tonsils and post lingual glands. In each case the departure from the tissue of its election, there is a radical change in the type of the inflammatory process.

The dangers of the disease are :—

1st. Life is threatened in the febrile stage by the effect of the excessive heat upon the nerve centers.

2nd. In the early stages by the involvement of the kidneys and consequent uræmia; and in the later stages, by both uræmia and dropsical effusions into the important cavities.

3rd. The involvement of the lymphatics of the throat and neck, threaten life by the formation of abscesses prone to be followed by pyæmia and exhaustion.

4th. Life is threatened by the involvement of the respiratory epithelium, and its underlying connective tissue. The involvement of the Eustachian tubes threatens; 1st., the loss of hearing; 2nd., life by the escape of pus into the cranial cavity.

## ARTICLE III.

**MEDICAL ORTHODOXY.\*** By T. D. WASHBURN, M. D., of Hillsboro, Ills.

An attempt to define, outline and apply to practice, ethics and legislation. Rather a large contract you say, I fully realize it. That a country doctor should attempt to define what medical orthodoxy includes, mark out its boundaries, portray its present condition and future possibilities, seems presumptuous; but if I succeed in arousing legitimate discussion and drawing out the various shades of opinion on this pregnant topic, I shall have done much to help to a better appreciation of the difficulties which surround it.

Most of you will admit there are some dogmas in medicine, as well as religion. We shall also concede that most dogmas have a certain element of truth in them. Now, if we can separate the true from the false, we shall have secured that much for orthodoxy; for orthodoxy is simply, true, sound doctrine. All medical men admit we have sects, or systems in medicine; (always excepting the venerable *Boston Medical and Surgical Journal*). These sects or systems have arisen from some cause. Now, I firmly believe the sect styled "regular," to which the label of "allopathy" has been attached by its opponents, embodies the most science and truth; still the most loyal will admit it has had many errors, that it is greatly modified, and in many respects, vastly changed. You may assert that medical science is a unit, and only embodies truth; but it is not a complete science, it is not matured; and to say that we, the sagacious, the genuine regular, alone represent, embody and contain all, is assuming what is not yet proven. When was regular and infallible medical science born? Who was present at the delivery? What nationality claims it? Not Switzerland, nor Germany, nor France, nor England! It was not born at all; like Topsy,

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\* This paper and the discussion following it, form a part of the transactions of the Tri-State Medical Society, which met in St. Louis Oct. 25th, 26th, and 27th, 1881.

"it grew." Its history goes back beyond the days when Dr. Isaiah applied the lump of figs to relieve his distinguished patient, King Hesikiah. Galen did not claim it, Paracelsus 1200 years later, was a bright and shining light, and had as much to do with its conception, or gestation, but he was not the father; he was as consummate a quack and irregular as anything ever begotten in the nineteenth century. It is a question of no little interest, to trace out the influence other sects have had on our own, but we cannot go into detail.

DOGMAS.—We can acknowledge this much, that Thompsonianism, with all its ignorance and bluster made a fearful onslaught on the use and abuse of calomel and the lancet, and when the smoke of battle cleared away, if not "*hors de combat*," we were more or less crippled. Subsequently, when Homœopathy landed from a foreign soil and divulged the ravings of the most noted lunatic the medical world ever saw, we learned rapidly some lessons we had grossly neglected, that nature was an immense power in the treatment of both acute and chronic disease; true, we were gradually skirmishing on that line, Prof. Bigelow of Boston, and Chambers of England, were pioneers in reaching the same truths, which the nihilismus of Hahneman forced upon us. Both these sects have had an influence on regular medicine. Unfortunately for us and the public, they managed to associate moral *reform* with their system, and thus created a "boom," a force and power, the American mind never stopped to analyze, but accepted as real. This gave them position at once, like Mormonism in morals and politics, which our wisest efforts failed to eradicate. One other item in this connection which greatly enhanced their strength; they boldly advanced to the front and scattered broadcast their views in the press; seizing our vulnerable points, they manipulated the public with essays and pamphlets and made things lively by their fulsome brag and shrewd manner of attack; while old regularity disdaining to fight with such weapons, and its venerable ethics forbidding any ventilation of their own practice, sat quietly in its citadel, conscious of its power, never ventured to repel an assault, but calmly waited to see one after another of its barricades broken down, its outposts driven in, and the enemy smashing things generally.

In the meantime, these reformers (?) were joined by fresh

recruits, some deserting from the old school; but they soon began to realize that a more perfect organization was imperative. They began purging its own ranks of some of its worthless material and bold nonsense, and retiring from positions which they could not hold, they seized for a rallying point, "*botanic remedies*," and labeled themselves "*Eclectic*." Here and there a medical institution termed college was organized, and as a diploma was a passport to greater respectability, they were freely given like the rains of Heaven to the just and unjust, the learned and unlearned. Bungling attempts were made to create botanic literature and text books, and thus, with brazen assurance they demanded and secured recognition; but with all this pretense and bluster, the old landmarks remained. Anatomy, chemistry, physiology, pathology, obstetrics and surgery had a rock basis and stood immovable. A knowledge of these was indispensable to any intelligent and successful practice.

All this time regular medicine pursued the even tenor of its way, stimulated somewhat by the pungent criticisms of its opponents, they gradually weed out the errors and refuse of the old system, and challenged the scholar and all thinking men to any adverse criticism. They proudly pointed to a century of statistical evidence manifesting their wonderful progress and development, and claimed unanswerably, their recognition as the true friends of science and conservators of all that was essential and meritorious in medical theory and practice. Gradually these diverse systems, dogmas and sects have drifted into close proximity. They recognize the necessity of the foundation elements which I have mentioned. You find our authors on their shelves; they prescribe from the same *materia medica*. Under these circumstances I see no objection to their children walking in procession with ours at the same pic-nic or festival. While I have shown as much hostility as any one, both in personal debate, the Society and our legitimate organs, the medical journals, my worst opponent will concede I have based my argument, not so much upon the peculiar Sect, or its advocate, as the ignorance it fostered, and the light it shut out, upon the chicanery and sham with which it was associated. But dearly as the American people love shams and admire cheek, when it becomes a matter of life or death, when it affects them personally, they begin to make a distinction between ignorance and good sense; between a milk-sop and genuine culture.

Unfortunately for the regular profession, while deeply conscious of its own merits, in its anxiety to scoop up what might wander to other folds, it so far forgot its high mission as to leave the *bars of entry* so low that *mongrel* stock became fearfully mixed with pure bloods.

Now, we may as well be frank. This was not the fault alone of the *cheap* schools, the nominal college which has done so much to demoralize and abase the profession, but the guilt lies largely at the door of the practitioner (and lies there to-day,) who encouraged some imbecile, or *half* educated young man to enter his office, and thus endorsed him to the college and the world. Thus the public were dazed, bewildered and puzzled; no wonder they failed to recognize the label of *regular*, when the *irregular* had brains and gave evidence of culture. Yes, our chickens have come home to roost, and no one to blame but ourselves. If we would not sweep before our own door, we have no business to howl about the dirt in front of our neighbor. No ethics can make ignorance respectable; no stamp enhances the value of spurious coin. Again, few realize what legitimate medicine has had to contend with. Of all science, *medical* science is perhaps the least perfect. It has had the greatest obstacles to overcome; the most insurmountable bigotry; the most venerable errors. Philosophy, religion, government; the whole frame work of society have been barriers to its progress.

No longer ago than the time of Galen, or even Paracelsus, the art and science of medicine was much in the condition of the earth at the time of creation, "without form and void," even the mud sills had not been found, much less the rock basis on which, with patient labor, the present grand superstructure has arisen. But notwithstanding its wonderful advance and maturity, we are still startled from time to time with new truths and brilliant discoveries which modify the old, and must be built into the new. Surely then, we have some difficulty in defining a standard of orthodoxy which shall fit all along the ages, and to which we can appeal as invulnerable amid the crumbling of Empires, and the shock of time! We can even afford to be a little tolerant toward our co-laborers who may differ with us, as we survey the past and realize what a chaotic condition we were in. How bitterly we have contended for tradition rather than truth, and how often have we been compelled to accept as truth, what for years we ignored and pronounced false.



How slow to accept even Harvey's demonstration of the *circulation*! And the grand boon of vaccination by Jenner, with all its beneficence and promise, was fought inch by inch by medical Solons. We are unwilling to appreciate what does not reach us through the most legitimate channels; we cling to the old. The "Moss covered bucket," and "Old arm chair," never lose their grip on us.

And gentlemen, our acknowledged leaders and brightest lights in the profession we dare not follow, if they have the temerity to announce something novel and unexpected. Virchow, when he advanced the cell theory, and backed it by argument and demonstration, was thought to be slightly visionary. How were the patient labors of Laennec in rational and physical diagnosis, and that invaluable application of auscultation to diseases of the lungs rewarded? With scoffs and sneers; and years elapsed before it was adopted and approved. So too, Louis on fever, settling once for all, the distinctive type of typhoid. Our own countrymen, Caldwell and Simms, in their special study of ovariectomy and vaginal fistula, startled us by their boldness, and reluctantly had our approval. Surgeon General Hammond, when he issued that order on calomel, gave great offense, lost his position, and now a score of years later, receives scanty justice for his wise and timely action. Again, Brown-Sequard seems likely to disturb some of our orthodox notions in regard to the nervous system, its laws, philosophy and manifestations, and it may be well to watch that Jewell of a man in Chicago, as well as the Hughes of light which strike us from St. Louis, or they may land us in unblushing heterodoxy.

With these facts, this fragmentary historical record before us, you begin to realize the status of medical orthodoxy; that its principles applied to practice, cannot be put in a cast-iron formula, but advancing and developing with each successive age, we claim the prerogative of modifying and perfecting the same, as the light and truth of science shall dictate. Shall we still persist in enforcing the most rigid supervision and discipline on such as dare to think for themselves? Have we not reached the conclusion that *knowledge* deserves respect and recognition? Is not knowledge the *sine qua non*, in all that pertains to medical science, as well as all science? And because one man's knowledge of the *same facts* leads him to different conclusions, convictions and results from our own, must he be ostracised and

tabooed? I like a well developed and firm spinal column, but why not have a little elasticity in this medical back-bone which reaches from the most erudite professor in our most cultured metropolis, to the hardy practitioner on the most distant frontier? Medieval darkness and ignorance could excuse and palliate such intolerance, but the blazing light of the nineteenth century forbids such an absurdity. Bigotry unadulterated is no worse! Let us at least concede to others, what we claim for ourselves, a manly independence. I met a commercial traveler a few days since; he had ninety different samples of coffee; and it reminded me forcibly of the condition of the profession. Yes ninety different kinds of one article, and no two alike;—that's us, the doctors, (genus, M. D.) ninety samples—all have the look, taste and smell of coffee. Well I need not stop to illustrate. Beaconsfield had *three* or more; our honored and revered Chief Magistrate, whose demise threw such a pall of grief and gloom over the Nation, had as many, and every city can boast of a score and they only differ like coffee, in their nativity, quality, flavor and richness. Some of you strolled through that wonderful art gallery at the Centennial, and may remember that vivid picture of Rizpah watching her gibbeted sons to scare away the birds of prey by day, and the wild beasts by night, for weary weeks. Some watch medical heresies with much the same vigilance. There is another striking picture I have not seen on canvas, where a great sheet is let down from Heaven, wherein were four footed creatures, wild beasts, crawling reptiles and birds of the air; and a voice comes to the bigoted Peter "rise, kill and eat;" what dismay; what horror in his resolute face; but when he learns a higher power has cleansed, even these, he submits and goes on his mission, to the gentiles in a manly way. Now brethren we have a little of this old Jewish intolerance. The medical gentile gets a wide berth, but seldom justice. This accursed caste which taints everything we touch, in religion, politics and social life, has not been thrust out of our medical sanctuary. This is not the spirit of orthodoxy!

A contributor to one of our encyclopedias has expressed the sentiment of the best element of the profession, when speaking of Homœopathy, he says; "The action of emetics in some kinds of indigestion, and of rhubarb in some kinds of diarrhœa, are familiar examples in daily use, showing that ordinary practice is not regulated by any blind prejudice against what is called the

homœopathic law of *similia similibus curanter*; but in these cases, the physician does not commit himself either against or in favor of the law, but sets it aside as a mere metaphysical abstraction, having nothing to do with the real principle of the cure, which is to be found in common sense and experience, applied to the facts of individual cases, and groups of cases.

"The true physician is not a sectary; he disowns all artificial formulas of cure, exactly as he disowns homœopathy; and he especially disowns the nickname of allopathist invented for him by Hahneman. His belief in remedies is not founded on extreme generalizations, and he refuses to be limited in his practice by any other technical rules, than those derived from a fair view of facts investigated on the ordinary principles of positive science." The same views apply to all exclusive dogmas and are the settled convictions of all well balanced minds.

It certainly is a delicate task to define what constitutes genuine orthodoxy in medicine at the present time. The foundations are being moved, a mighty upheaval is going forward, and some of these old foggy medical notions, and fossil leaders will be upset if they do not yield to the spirit of the age, and give up their antiquated and imbecile traditions and accept untarnished and immutable truth.

[ TO BE CONTINUED ]

## ARTICLE IV.

## THE DANGER OF SUDDENLY WITHDRAWING ALL OPIUM FROM OPIUM EATERS. By C. H. HUGHES, M. D., of St. Louis.

Within the past month two cases in the persons of medical men have through their friends for they were too helpless mentally to seek aid themselves—sought relief from me for the dangerous effects upon their minds of the sudden and complete cessation from the use of morphine to which they had become chronic habitués, each consuming as near as could be ascertained, about ten grains of the sulphate daily. These cases recall a great many others of a similar character that have come under observation of late years and remind me of a duty too long neglected of sounding a note of warning on the subject.

The morbid cerebral condition of chronic meconism is far preferable to the profound mental aberration—frequently delusional mania after dementia—which, often supervenes upon the sudden stoppage of large habitual doses and sometimes follows the quitting of very small ones.

If only intense pains, catarrh and diarrhœa follow the abrupt abandonment of the drug the opium eater may be safe enough. He may retrace his steps to make the trial again under more favorable auspices in an institution especially adapted or under the direct care and supervision of a physician of some experience in these cases; but if dementia follows the unassisted self attempt, the victim is helpless and in danger of permanent injury. Besides the unadvisability of inducing a single attack of insanity under any circumstances because, not of its immediate peril but of the predisposition which it engenders to another attack, to fall into the hands of even the most skillful physician under such circumstances is extremely embarrassing to the physician who treats the case. He is deprived of the exact knowledge as to the amount of the drug taken as, to the natural mental characteristics of the individual and of the benefit to be derived from

inquiring of the patient as to rational symptoms etc. so helpful to him in many respects in the treatment.

The Opium habit should be abandoned by nearly all who indulge in it. I will not all for there are times and cases when and where abandonment is more perilous than continuance, but when it is resolved to give it up it should not be recklessly thrown off regardless of time or place or season. The giving up of the terrible indulgence should be deliberately resolved upon, a judicious medical advisor selected, who is to be the constant companion of the victim during his ordeal, business affairs should be arranged so that they need not be attended to for a while—not less than six to eight weeks of respite being provided for—and the habituate should if possible go away from home either to the house of some physician fully posted in combatting the symptoms arising from the withdrawal of the habitual influence of the narcotic on the nervous (and medical men so informed are comparatively few) or to an institution for the treatment of these cases having all the necessary nursing, skill remedial aid at hand for use in every emergency.

The peculiarity of chronic meconism is that like a stealthy and skillful villain, it wounds without attracting the victim's attention till the mischief is consummated and covers up the destruction made so that detection is not immediate. Each successive dose covers up the mischief of its predecessor and when the poison is no longer repeated the danger to the organism is revealed. It is then fortunate for the victim of sudden withdrawal if only the sensory or motor tracts of the cord reveal the harm they have received in pain or tremulousness, or only the sympathetic system shows its injury in emesis, profuse perspiration or diarrhœa that can be self managed by the well informed medical victim; but if the damage cortex reveals extensive injury in delirious mania or dementia the situation of the victim is alarming and perilous, for the time at least and the only recourse in many cases is to cautiously feel our way back with the patient to his starting point (whatever quantity that may have been) of abrupt abandonment and begin with him again with better understanding and better preparations for the combat. A patient a medical man once consulted me from another with city less than a hundred dollars in his pocket for all contingencies saying he had been taking half a grain of morphine daily and had come to the city to spend a week or two and get

rid of the baneful habit. He lied as most of these patients will on this subject. The next day he had delirium and no attempt on my part had been made to reduce this amount. On the contrary, suspecting that he had misconceived what a trial was before him and deceived me, I began to increase the amount and he did not regain the normal use of his faculties till he had reached a daily dose of ten grains. It is perilous to suddenly withdraw large amounts of opium in chronic habitués without the victim being well prepared and surrounded for fighting grave symptoms. It is possible thus to precipitate or irremediable insanity, as I have seen in more than one instance, though by judicious management the patient may generally be brought back to sanity; but the most certain evil of abruptly breaking off, is the damage to one's reputation and business.

I may add in conclusion of this hasty note, that to rely on any *one drug* like the vaunted *Erythroxylon Coca* is a delusion and a *snare*.

## Translations.

### ARTICLE V.

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#### FROM THE FRENCH.

EXCERPTS FROM LATE FRENCH JOURNALS. [Translated for the JOURNAL.] By A. H. OHMANN-DUMESNIL, A. M., M. D., of St. Louis.

TREATMENT OF PHTHISIS.—M. Debove had in his service, a phthisical woman who could no longer support milk, and he decided to feed her through an œsophageal sound. By this means he administered at first a litre of pure milk, later meat and eggs. He succeeded in injecting two litres of milk, 200 grammes of meat and ten eggs in a day. The most singular part is that the patient's appetite returned, she increased in weight 100 grames a day, sleeps well, and night sweats have disappeared.—[*France Médicale*.]

CHLORAL HYDRATE IN TOOTHACHE.—According to Sporer it suffices to take a few small pieces of chloral, about 5 centigrammes, and crush with cotton and introduce into the painful cavity. The chloral dissolves, and the pain is dissipated in a few minutes. It is a good means of curing dental caries.—[*Paris Médical*.]

CURE OF GLAUCOMA BY EQUATORIAL SCLEROTOMY.—M. Nicati makes a sub-conjunctival puncture with a bistouri carried to the vitreous body. This latter must protrude through the wound. If this condition of hernia can be made to persist a cure of the glaucoma will be effected, according to the author. This operation brings about a sedation of the pains, in diminishing the exaggerated distension of the ocular globe; but it does not cure the glaucoma, it merely obviates the consequences of that affection.—[*Ibid*.]

CREASOTE FOR SYCOSIS.—Sycosis, which is so often treated by

epilation, is sometimes cured by repeated applications morning and evening of the following ointment.

Benzoated Lard.....	0.30 grammes.
Oxide of Zinc.....	0.6      "
Creasote.....	20 to 30 drops.

The affected parts are then covered with courtplaster.—[*Ibid.*

**DENTAL EROSION.**—Dr. E. Magitot in a very exhaustive paper on some clinical studies on the erosion of teeth considered as a sign of former infantile eclampsia, arrives at the following conclusions:

1st. Infantile eclampsia constantly produces a disturbance, in intra follicular nutrition, which becomes manifested in a characteristic lesion of dental erosion.

2nd. The *level*, *number* and *extent* of the lesion of the crown correspond to the *time*, *duration* and *intensity* of the eclamptic attacks; erosion is *one*.

3rd. Other diseases of childhood are incapable of producing erosion. Grave and long continued sickness may bring about a total disorganization of the crowns of the teeth in the course of evolution, but not erosion properly so-called.

4th. Hereditary syphilis, whose influence upon the formation of osseous and dental tissues cannot be denied, is never evidenced by the characteristic lesions of erosion.

5th. Examples of dental erosion have been found in pre-historic formations, and according to the reasons advanced by Broca and others, are proofs of infantile eclampsia, which constituted the object of cranial trepanation.

6th. Dental erosion in its most characteristic forms is not restricted to man, but can be found in domestic animals not subject to syphilis.—[*Gazette des Hôpitaux.*

**MICROBION OF ACUTE PEMPHIGUS.**—M. Gibier de Savigny thinks he has discovered the infectious agent giving birth to acute pemphigus or pemphigoid fever. It is a mobile bacteria, formed of a series of articulations disposed in bracelets, and existing in the liquid of fresh bullæ and in the urine. The search of the microbion in the blood and injections made in animals, after



culture of the liquid according to Pasteur's method, has only given negative results so far.—[*Progrès Médical*.

URINARY FISTULA.—NEPHRECTOMY.—CURE.—M. Le Dentu, Surgeon of l'Hôpital St. Louis, in March 1875, was called to see a patient, aged 32, having a fluctuating tumor of the left side and iliac fossa, hydronephrosis or perinephritic abscess. He incised the tumor, allowing a clear liquid to escape and showing it to be a hydronephrosis. From this a urinary fistula was established. As life was endangered several times by inflammation, etc., nephrectomy was proposed. The 14th. of April the operation was performed, the kidney being found degenerated in its upper two-thirds—converted into a pocket with flaccid walls—and its lower third normal.

Two ligatures were placed about the healthy portion of the kidney, and the rest excised with scissors; the dressing was carbolized. For several days the patient was very weak; pulse 120 to 145; temp. 38° C. (100° 4 F.) to 39° 5 C. (103° 1 F.) a contrast between the pulse and temperature as is observed after hysterectomy.

At the end of two months the wound in the lumbar region had healed. The inguinal fistula suppurated for a fortnight, having been cauterized, but soon healed also, except a part in which a small drainage tube had been kept, and which furnishes but a few drops of purulent serum per day. In a short time it will be completely closed. The urinary functions are perfect. The general health is excellent and the patient who is a distinguished actor has been enabled to make a brilliant re-appearance on the stage seven months after the operation.—[*Bull. de l'Académ. de Méd.*

## ARTICLE VI.

## FROM THE SPANISH.

STUDY OF THE ETIOLOGY AND NATURE OF BERIBERI. By Dr. A. Pacifico Pereira. Translated from the *Gazeta Medica da Bahia*, for the JOURNAL by Jos. WORKMAN, M. D., of Toronto, Canada.

The history of the recent voyage of circumnavigation by the Brazilian corvette *Vital d' Oliveira*, as described in the minute and elaborate report received by us a few days ago, from the chief surgeon, Dr. Galdino Cicero de Magalhães, has furnished to us still further very useful data for the study of Beriberi, which was epidemically developed on that vessel of war during a long passage from Yokohama to San Francisco, under conditions which were carefully studied by that illustrious colleague.

The description of this epidemic, and of its causes, the meteorological conditions coincident with its appearance, the mode of its termination, the hygienic conditions of the ship, and in short, all the circumstances detailed, corroborate the observations before made by us, and concur in showing that Beriberi is due to an anoxhæmia, produced by the prolonged action of special meteorological conditions, and other causes which produce insufficient oxygenation of the blood and diminish the scale of physiological combustion in the different tissues of the organism.

The first cases of Beriberi, on the *Vital d' Oliveira*, appeared at Ceylon, in May 1880. Dr. Galdino de Magalhães describes the mode of appearance of the disease thus: "A few days before our arrival at Ponta de Galles, some cases of œdema about the ankles appeared, which were extending. In the preceding days, the hull of the engine had begun to exhale a nauseating smell from the waters and grease lodged there; this exhalation stained the metals and yellowed the white paint. I attributed the swelling to a miasmatic poisoning, and decided on the treatment, under this impression. Peruvian quinia, arseniate of soda, ali

mentive and analeptic tonics, partial warm baths, frictions with balsam of Fioravanti, digitalis, colchicum, salts of tartar and some purgatives, subdued a part of these affections.

Others, however, did not yield; the swelling invaded the legs; there was feebleness in locomotion, pain in the knees, epigastric tightness, vomiting in some, tottering gait, digestive atony and other symptoms which were regarded as resulting from Beriberi. Relying on our prognosis, we employed granules of arseniate of iron, sulphate of strychnia, phosphoric acid and quassia, decoction of barley with addition of digitalis and aconite, saline laxatives, frictions with the balsam of Fioravanti, camphorated or terebinthinated volatile liniment; salt baths, electric shocks by the interrupted currents of Gaiffe; and wine of quinine in the aliments. From the employment of these means the symptoms sensibly declined in force. The cedemas became limited to the ankles, muscular energy was restored, digestion became vigorous, and the other symptoms went on decreasing to their complete extinction."

Consulting the nosological and meteorological maps which accompany this very elaborate report, we see by the meteorological one corresponding to the month of May, in which the Beriberi appeared, the maximum of the thermometer marked 38.5 (Centig) (92.3° F.,) and the minimum 27.5° C. (81.5° F.,) the hygrometer showed 88° maximum, and 73° minimum; the barometer gave 761.6 mm. (29.98 inches) max., and 756. min., (29.76 inches).

In the following month the temperature was lower; the max., therm., was 30.5 (86.9 F.) the minimum 20° (68° F); the max. barometer 761.5 (29.98 in.,) and min., 754.5 (29.68); the maximum hygrometer, however, reached 100° (saturation), and the minimum 71°.

During this month, from the 1st., to the 18th., the corvette was anchored at Hong Kong; and from 21st., to 26th., at Nangazaki, whence she proceeded to Yokohama.

In describing the sanitary state of the vessel in the month of July, the report states:

"During our stay at Japan, and through a great part of the voyage, we were under the continued action of showers and overcloud. The hygrometer showed constantly great atmospheric humidity, reaching on several occasion the maximum of 100, —the point of saturation. The moisture was such that the lower

apartments were kept cooled, as if they had been steeped. The crew were exposed to these injurious influences, without protection from the rain, as their clothing had been worn out early in the voyage."

Farther on the report says: "We have also recorded the large number of individuals attacked with œdemas, without any appreciable cause. I regard these as the results of the saturation of humidity in which we lived, as I found no organic lesion which might account for them."

By the meteorological map it is seen that from the 1st., to the 20th., the temperature oscillated between 30° (86° F.) and 18.5 (65.3); from 20th., to 31st., it descended to 11° (51.8); the hygrometer showed during the month, maximum 100°, and min. 72°; the barometer, maximum 768.5 (30.26), and min., 751. (29.57.)

It was, however, in August that the epidemic of Beriberi broke out on board, fully prepared for by the preceding circumstances, and still more by the bad condition of the ventilation of the ship, as we shall see in another part of the report relating to the hygienic state of this vessel of war. As regards the epidemic, the report states as follows:

"The first 20 days of August we passed in the voyage to San Francisco, California; when we arrived at this date, and closed the month at anchor in this port. Our sanitary state was very bad in this month. The Beriberi was developed epidemically in a frightful manner; attacking its victims profoundly, and running on to fatal termination.

"The history of the development of Beriberi on board this corvette is long. The first cases were observed in the Yellow Sea, and were combated with adequate treatment, as appears from the maps of this period. They reappeared in this passage with unheard of violence, after a series of circumstances which much enfeebled the crew."

"Continued long showers, dense overcloudings, moisture, want of protecting clothing, insufficient nourishment, want of wine or any alcoholic, abuse of wet scrubbings, little rest, etc., were the causes which were operative in the reappearance of the disease. Twenty-nine individuals were attacked more or less gravely, three of whom succumbed on the voyage."

On arriving at San Francisco the patients were sent to the marine hospital of that city. From the *Medical Record* of New

York, of Dec. 25th., we transcribed into this *Gazeta*, what Dr. Hebersmith, chief surgeon of the San Francisco hospital said of these cases of beriberi, in a report to Surgeon General Hamilton.

"It is a disease from faulty hygiene, modified in its causality by local, climatological and perhaps hereditary influences producing its primitive effects on the sanguineous corpuscles, causing the disintegration and death of the red corpuscles and augmentation of the white—the effects on the heart and the circulation are secondary,—as are the effusions; all ensue as a natural consequence of the alterations in the blood, and the proper treatment is the renovation of the blood.

"Certainly the result of the treatment of these patients shows the correctness of the ideas above exhibited. Of sixteen cases two died on the day after admission, and one on the fourth day. Nine recovered, and four remained in hospital convalescent, awaiting transport. Some of those discharged, met with cold weather on their journey to the east, and felt the result of it. As it is a disease with relapsing tendency, some of our confrères in the east may have the opportunity of studying it."

We are certain that Dr. Hebersmith's fears have not been realized. Relapse of Beriberi is not usual unless in climatological conditions very different from those encountered by the patients disembarked there from the *Vital de Oliveira*, and those of temperature entirely opposite in the United States during winter.

At San Francisco during the stay of the corvette in that port the temperature ranged between 20° (68° F.,) and 14.5° (58.1 F.,) only once reaching 24° (75.2°); the max. hygrometer was 78, and the min. 72°. The rapid improvement of the patients, with the exception of the three who entered in a very advanced state, was not, as Dr. Hebersmith thought, the simple result of the treatment adopted; it was principally due to the influence of the climatological conditions met by them. This alone is sufficient to cause Beriberics, when the disease has not yet reached that advanced phase in which the lesions of the nutrition of the textures have become irreparable. It is a fact which we have observed constantly, that a voyage to a temperate climate rapidly cures Beriberics, without the aid of pharmaceutic medication, when the disease has not yet reached a very advanced period in its march.

In future chapters on this subject, we shall treat of this point more minutely.

[TO BE CONTINUED.]

## Original Lecture.

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### ARTICLE VII.

**LECTURES ON FRACTURES AND DISLOCATIONS: By Jno. T. HODGEN, M. D., Professor of Special Fractures and Dislocations and Surgical Anatomy, in the St. Louis Medical College.**

#### I.

**A CHAPTER FOR MEDICAL STUDENTS.—FRACTURES IN GENERAL.—VARIETIES AND CAUSES OF FRACTURES.—INTRODUCTORY REMARKS.**

With this lecture we begin the consideration of fractures. Authors define a fracture as a solution of continuity. The word fracture expresses as much and quite as clearly. Bones may be broken through; or the fracture may run part way through a bone. If broken entirely through, it is complete. If part way it is incomplete. Of partial fractures there are two sub-divisions, fissure and green-stick fracture. In the green-stick fracture, the fibres of the bone not broken, are bent. In the fissure, the fibres not broken, are not appreciably bent.

There are other sub-divisions of fractures, divisions dependent on the direction of the fracture, in reference to the axis of the bone, as transverse, oblique and longitudinal. Strictly speaking, all fractures of long bones are probably oblique; for it is scarcely possible that a bone be broken exactly through its axis or precisely at right angles to its axis. But these definitions must be modified. A transverse fracture is one, practically, in which the break runs so nearly transverse that when the fragments are brought together, one fragment will support the other so that there will be no shortening; yet, the general line of the

fracture may be oblique. When the fragments are replaced, and the line of fracture is so oblique and so smooth that the one slips by the other, it is practically an oblique fracture. Fractures are sometimes denticulated and serrated. A denticulated fracture is one in which tooth-like projections of one fragment, correspond to depressions in the other, like the fingers of one hand dovetailed into the fingers of the other. In the serrated fracture, the tooth-like projections are smaller and more numerous. Now we may have a fracture which is transverse or oblique in direction, and denticulated or serrated in form. If the line be oblique and the serrations or denticulations be of such a character as to prevent one fragment gliding over the other, it would practically be a transverse fracture.

When we come to the healing of bones, we shall speak of changes of the tissue which makes it possible for a fracture at one time transverse to become oblique without changing the general direction of the line of fracture. A serrated fracture traversing a bone obliquely may be so adjusted that the fragments support each other, and maintain their proper relations the projections of one fitting into the depressions in the other. But after eight, ten or twelve days, there is a softening of the bone along the line of fracture and the projections disappear so that it is not possible for one fragment to adjust itself on the other. The ends slip by each other, and that which was practically a transverse, becomes practically oblique. At the City Hospital was a fracture of the tibia in which the line of fracture was oblique; the fragments were adjusted and fitted one upon the other. When the second dressing was made it was found the softening of the tissue had altered the line of fracture, the little tooth like projections had disappeared, so that the surfaces were smooth, and the fragments had slipped by each other. Thus we had a transverse fracture converted into an oblique one. Fractures are simple, compound, comminuted and complicated.

#### SIMPLE FRACTURE.

A simple fracture, strictly speaking, is one in which a bone is broken in one line and at one place without the involvement of any other tissue. But it is not possible to have such a condition of things. The periosteum is always and necessarily injured.

Practically, a simple fracture is one in which the bone is broken into but two pieces, in which there is no opening in the skin communicating with the fracture, in which the fracture does not communicate with a joint, in which no serious damage has been done the soft parts in immediate contact with the site of the fracture. In other words, it is a single line of fracture with such trifling injury to the surrounding parts as not to interfere with the usual process of healing.

It may be complete or incomplete; transverse, oblique or longitudinal; serrated or denticulated, and yet simple.

#### COMPOUND FRACTURES.

If there exist an external wound communicating with the line of fracture it is compound however the wound of soft parts may have been made, and however great or trifling it may be.

#### COMMUNUTED FRACTURE.

If the bone is broken in more than one line, and the lines of fracture communicate, one with the other the bone is said to be comminuted.

#### MULTIPLE FRACTURE.

If there be two or more lines of fracture in the same bone not communicating one with the other, it is a multiple fracture.

#### COMPLICATED FRACTURE.

Fractures associated with serious injuries of joints, ligaments, tendons, muscles, nerves and blood-vessels are thereby complicated and known as complicated fractures.

#### IMPACTED FRACTURE.

The dense, hard shaft may be driven into the porous, open tissue of the end of a bone, making an impacted fracture. Thus the radius is expanded toward the lower end, it is open and porous, the dense shaft above may, by a fall on the hand, be driven into the open cancellated tissue of the lower end, making an impacted fracture.



Or the dense outer lamina may be driven into the porous central part of a spongy bone. You will observe then that impactions would from the very structure of bones, occur most frequently toward the ends of the long bones and not in the dense tissue of the central part of the shaft. In growing subjects bones sometimes break at the epiphyseal lines. These epiphyseal separations are in all respects fractures, they are to be treated as such, they unite by bone, and not by cartilage, thus obliterating the epiphyseal line when the union is completed. Hence it occurs, if the bony union takes place in very young subjects, the bone does not grow as rapidly as its fellow.

Fractures of the shaft are more frequently transverse in young and old subjects, while in the middle periods of life, they are more frequently oblique.

Fractures of the patella and olecranon are generally transverse, probably because, when subjected to direct violence, the muscles aid in the separation and determine the direction of the line of separation.

The influence of muscular action in these fractures is shown in the fact that fractures of the patella and olecranon are comparatively rare in young and very old subjects, while they are of frequent occurrence in the middle periods of life, when the muscles are especially vigorous. These bones are rarely fractured in females whose muscles are much less developed than in the opposite sex.

#### CAUSES OF FRACTURE.

The causes of fracture are predisposing and exciting. Predisposing causes are physiological and pathological. The physiological relate to age, sex, occupation, muscular development and nervous irritability. The bones of the old are more fragile than those of the young. The infirmities of age abridge or suspend the special functions of bones, and thus impare nutrition, and alter the structure of bones, and thus render them more liable to fracture. While the bones of females are more slender and fragile, the opposite sex suffer fracture more frequently because of their greater exposure to accident, and greater muscular development, fractures from muscular action are more frequent in subjects whose nervous irritability is such as to excite sudden and violent muscular action.

The pathological predisposing causes are such as alter the structure of bones. Wasting diseases and especially such as insure long inaction, render the bones fragile.

Mollities ossium, rickets, syphilis or ostitis predispose to fractures by pathological changes.

#### EXCITING CAUSES.

External violence and muscular action, are exciting causes of fracture. External violence directly applied at the site of fracture, as when a blow falls directly on the ulna while protecting one's head from a blow; or indirectly applied, as when a Colle's fracture of the radius results from a fall on the hand. All the bones of the body are liable to fracture from direct violence; while the long bones are more exposed to fracture from force applied indirectly. The bones most frequently broken by muscular action in the order of their occurrence are the patella, olecranon, humerus, femur and calcaneum.

[Jan.,

## Proceedings of Medical Societies.

### ARTICLE VIII.

#### ST. LOUIS MEDICAL SOCIETY.

Taken by the JOURNAL's Stenographic Reporter.

SATURDAY, Nov. 12th. 1881.

Dr. Blount was invited to exhibit a stethoscope, modified by himself.

#### Improved Stethoscope.

DR. BLOUNT—Mr. President: I have used different kinds of stethoscopes but I find I can hear better with this one which is simply a modification of the ordinary stethoscope. The advantages which I claim for it are that it is not so cumbersome, is more readily carried about, and is not liable to the objections that is made to the ordinary stethoscope, that it causes pain to the ear. It is of a convenient length to keep the physician from contact with the patient.

DR. PORTER—There seems to be a great antipathy among many physicians to the stethoscope, and possibly in individual cases this is well founded; but the objections urged are not always valid. It is at least disagreeable sometimes, to put your ear close to the patient's chest, it may be for the patient's sake, possibly for your own. It is not every patient by about 99 per cent. that you would like to thus examine in hospital practice. It is not every patient in private practice who would willingly have the physician's ear close to the chest. Again, it is questionable whether with the unaided ear you are able to eliminate sounds except the one you seek. With the stethoscope you may certainly do this. I have a case of aneurism at the arch of the aorta in which I think I would have utterly failed without the aid of the stethoscope. My preference is decidedly for the double stethoscope. The doctor objects that the spring that brings the arms together presses often too firmly. In my instrument the spring is set by a little shoulder

screw which is so fixed that it holds its position and causes the bells to press against the ear without much force. The choice of a stethoscope requires as much judgement, almost, as the choice of a microscope. The double stethoscope, when properly used—and this can be done after a little practice—has no equal. In the country, the single stethoscope has the advantage of being more easily carried.

Dr. HUGHES.—In 1856 or 1857, I saw for the first time Dr. Cartwright, of New Orleans, who was profoundly deaf and he carried in his pocket a flexible tube which he used as an ear trumpet. When he came to the house of his brother-in-law, Dr. Leisel, with whom I was staying, he rang the bell and a servant appeared, he took the flexible tube out of his pocket and the servant ran back into the hall and up stairs and said there was a man down stairs who had pulled a snake out of his pocket and he didn't know what kind of a man he was. Dr. Cartwright used this as a single stethoscope. It is a little singular that the single flexible stethoscope has not been more in use. I don't recollect seeing one at any of our instrument makers in this city. There is an objection to the double stethoscope that is, that they are made, partly of metal and that they do conduct sounds from without the ear, and whilst gentlemen who are so expert as Dr. Porter is, would probably be able to differentiate between the sounds of the foetal heart and the noises coming from without, every man cannot make an examination of that character. These flexible tubes are certainly preferable for conducting sounds as Dr. Porter has said, but if he has used those which are part flexible and part inflexible, in which the metal tube comes in contact with each ear he certainly must have discovered how intently one must examine the patient, sometimes to exclude the sounds from without. It strikes me, that besides the question of delicacy in examining females, one has an especial advantage by using the stethoscope, as it enables us by getting the stethoscope higher up under the mamma, to make a better examination than we could otherwise do. And so in examination of the throat; no one can get at the throat, at least very few persons, and they must have very small heads, or else the neck be very long, so as to make a perfectly accurate examination of the tracheal and laryngeal sounds. And there a stethoscope is particularly valuable. And besides it is useful in fixing the location of special heart sounds

and definitely circumscribing sounds within cavities. I have no doubt that this is a real improvement. I have not seen any of these flexible tubes in the stores here, nor have I seen them described in the catalogues.

DR. ROWLAND.—They can be had in Louisville, Cincinnati and New York. I have had one for the last fifteen years—never been without one. My single stethoscope is something similar to this one, with a flexible tube very much like this.

It is not just like it. The tube is about the same length. The bell is not shaped exactly like this however. The bell is a little larger.

#### **Destruction of Metacarpal Bone of Thumb.**

DR. BERNAYS.—If it is in order, I would like to show a case. This patient I treated about a year ago for complete destruction of the metacarpal bone of the thumb. A part of a planing machine struck the metacarpal bone in the middle, and crushed it into quite a number of fragments, tearing away a good deal of the skin and muscles. I found it necessary, upon examination, to remove the fragments and also both ends of the bone; and then, of course, this bone being taken out, the thumb just seemed to be perfectly loose, and of no earthly use whatever, and I told the patient I thought probably it were better to amputate it, but if he were willing I would leave it and see what would become of it. I didn't think it would be of much use to him. The patient was willing, and so I left it. It didn't unite very readily, but became much inflamed; the patient had high fever for a few days, and the arm swelled up immensely, as far as almost to the elbow. There was a great deal of pus discharged. After it happened I asked Dr. Fairbrother to see the case; he also told the patient he didn't think the thumb would be of much use to him. If you will examine the case now, you will find that the phalanges of the thumb have come down upon the carpus, and that the patient has a very useful thumb.

DR. FAIRBROTHER.—I took a great deal of interest in this case. I saw it during its treatment and, at that time I had a similar one under treatment in which about half of the third bone of the thumb was removed with a result hardly as good as this. There is hardly as much retraction—the ends of the bone not coming nearly into apposition. Such a result as this will take

place sometimes. If there is no retraction, if the ends of the bones are not nearly in apposition the thumb is worse than useless, hanging limp and without power or motion. This thumb was badly injured, not only the bone, but the soft parts being largely torn away. When I saw it with the Doctor, I spoke of the propriety of removing it. He informed me that he had recommended that course from the beginning, thinking that it couldn't possibly be of any value, but still there is no harm in leaving the thumb as it may possibly be of some use, as we see in this case.

**Continuation of the Discussion on Phthisis.**

DR. STEVENS.—Mr. President; I was very glad that the discussion of this question was continued till to-night for the reason that I did not consider it fully discussed at the last meeting. In fact, it seems to me that the main question was hardly touched upon at all. I don't wish to enter into the discussion, but I would like to suggest one or two points that may, perhaps, elicit some remarks from others. If I understood Dr. Bernays on last Saturday evening, he told us that a particle of dust might enter into the lungs and by the accretion of other substances—morbid matters—it might become tuberculous. Is that it, Doctor?

DR. BERNAYS.—I said if a particle of dust were injected into the blood vessels, then, wherever one of those little particles is lodged it will give rise to the formation of a genuine tubercle.

DR. STEVENS.—That is about the same, I take it. And also that in a fracture of a bone, if some of the pus or diseased bone, or something of that kind, be taken up by the circulation and deposited in a gland or in the lungs, that also will become tuberculosis. The place where it is deposited becoming the nidus or furnishing the hatching point at which the tuberculosis is originated. Now this is a different idea from what I had entertained. I had been taught, and from my reading supposed that tuberculosis was definable—*sui generis*—was something that could be described. For instance, miliary tubercle was something that was inherited, perhaps, so that it was found in the lungs of the fœtus, of the child, of the grown man and of the aged man. Perhaps it was developed, sometimes never developed. I supposed that tuberculosis was something of this kind, and that it was distinct from other morbid matters. Now if I am wrong in this, I would like to be corrected. If it is true that in an indi-

vidual with perfectly healthy lungs, a particle of dust can be introduced, or by getting into the circulation somehow, it can become tubercle and give rise to other tubercles, and so result in tuberculous disease of the lungs, or anywhere else, I would like to know it. Those who are more familiar with the subject than I am may be able to tell what the opinion of the profession is on the subject.

DR. BERNAYS.—I just want to make an explanation in a few words of the statement I made in regard to the production of tubercle by injection of dust, or any sort of dirt into the circulation. In the beginning of 1870, Cohnheim made an experiment by cutting out from a cadaver some small particles of tubercular deposit in the lungs. He ground this in a mortar and made it soft by mixing it with some fluid so that he could inject it into the blood of animals—perhaps rabbits and frogs—and he found that wherever some of these little particles lodged there was formed around it a miliary tubercle in every respect answering the anatomical definition of tubercle. Now came W—r—d—m and began to inject all sorts of things. He injected little pieces of wens and found that they produced tubercle also; then he injected some dust and got the most beautiful miliary tubercles. Wherever they found these particles of dust with the microscope, there was a tubercle.

DR. PORTER, after giving by request, a synopsis of his paper, said: The so-called tubercle produced by the inoculation of dust, etc., is not true tubercle and I am borne out in this by the recent researches in pathology, Cohnheim's among them. It produces a condition which resembles tuberculosis, but is not true tubercle. Just as we have a condition which, under the microscope is like syphilis, yet a comparatively harmless condition; and you cannot tell syphilitic pus—pus from a chancre—from ordinary pus, yet we know that there is a causative difference between them. And so with the tubercle produced by the injection of anything except the true tubercular material. The point taken is this, that the absorption from a non-tubercular ulcer can not possibly inoculate and produce tuberculosis. There may be auto-infection, the result of the absorption of pus from a tubercular ulceration—a tubercular process—or there may be inoculation from an extraneous tubercular source.

DR. JOHNSTON.—Did you ever know of a case of tuberculosis that was produced by any non-tubercular substance?

DR. PORTER.—No sir! I have not.

DR. BERNAYS.—I would like to ask how, if you take the position that tuberculosis is a specific disease, how do you explain its origin? You cannot explain its origin any more than you can explain the origin of syphilis. I take the position that it can be explained, but you say that it is specific and thereby give up everything; for you stop scientific research.

DR. HUGHES.—I believe the nature of tubercle is not under discussion; nor is the question of the tubercular diathesis. I believe it has been long conceded that there is a diathetic condition of persons which makes them prone to contract one disease or another, which makes one person prone to have tuberculosis upon the reception of a certain irritation within the lungs; just as there is a rheumatic diathesis by which one who is exposed to cold will display rheumatism, while one who is not prone to that affection escapes. Two individuals take a cough, an ordinary bronchial irritation. One of them will recover in a short time from the cough, while in the other it will pass on into phthisis pulmonalis. It seems to me that that question is settled. I think that there is no division in the profession as to that fact whatever. I think it is admitted by all that there does exist a diathesis which makes one person prone to phthisis pulmonalis, while another may escape, under the same circumstances. I don't think we should take time to discuss these side issues. There are questions enough that hinge on phthisis pulmonalis to occupy us a dozen nights.

DR. MUDD.—I should like to call the attention of the society to the points at issue, again. It seems to me that we can all agree that these long continued suppurative actions, at whatever stage or wherever located, will develop, sooner or later this tuberculosis, whether the predisposition to it was marked or whether it was slight. We all agree that the suppurative action should be limited if possible; and I think that we may all agree that, if it is not the exciting cause, it is a very strong predisposing cause to the development of tuberculosis. It does, I am satisfied, produce tuberculosis in those in whom the diathesis is not perceptible, in whom there is no evidence of it, in



whom it cannot be traced, cannot be determined and in whom I don't believe it exists.

The practical point that I had in my mind in suggesting the subject was this: What is the influence of these suppurative actions upon the progress of the tubercular condition in the lungs after it had once occurred, after the tuberculosis was established? It seems to me that the same conditions that would develop the predisposition, and so establish the tuberculous condition of the lung would hasten that progress; and I think this is the practical experience of those who have made the usual observations upon those cases. Surgeons who have observed these long continued suppurations of bones about joints have found that, where tuberculosis was present, where the lungs were being infiltrated, where there was more or less softening of the lungs, they found that, after amputation of the suppurating part; the general condition of the patient improved, the lung became comparatively sound again, the portion that was breaking down healed, and the deposit was in part removed. This is the experience of Bryant, Sayre and other surgeons who have made close observations upon such cases. I believe these ulcers are often connected with the tubercular degeneration; fistulæ in ano in the great majority of cases, are of tuberculous origin when they occur in tubercular patients. I think it occurs more as a result of mal-nutrition, and if there is any drain it produces a depressing effect, it exhausts the patient, it disturbs the nerve force and disturbs nutrition. Thus in ulcers of the rectum, the practical point is whether we are enabled to cure them. I operate on them and try to stop this drain, and I believe it is a good practice to stop this drain, and I believe it is a good practice to remove these sources of irritation, remove the ulcerated point as far as it is possible and the question turns upon this point; how far as it possible to do this. As I say, surgeons have, in the last ten years, observed that if they operated for these joints, made an amputation for the cure of ulcers, or operated for fistula in ano, there was a marked improvement in the condition of the patient.

Dr. Porter's paper in which, if I understood him correctly, he said that in those patients afflicted with tuberculosis, who had an ulcer or fistula, or a local inflammation, with great disturbance of the lung, if the nutrition was comparatively good, and if the patient was not rapidly breaking down, we should simply endeavor to improve the general nutrition and look directly to

the local source of trouble. Now it is true that the ulcer will not heal when this degeneration is marked, when the breaking is rapid, but if the patient's condition be improved by the hygienic measures to which he has resorted, he is in a condition to be operated upon for the removal of the ulcer, and this should be done because the cure of the local trouble will hasten the improvement of parts which we cannot reach. I cannot understand how it is, or that it can be possible that ulceration or suppuration will prevent or retard the degeneration of the lungs when once tuberculosis has been established. It seems to me that the drain sometimes does produce this depressing tubercular degeneration and hastens the progress of the case. This came to my mind practically, a few weeks since. A man in the hospital had a tubercular degeneration of the lung, with some softening, I think. He had also an ulceration about the ankle joint. I amputated the leg and the stump healed, and since that the cough has been rather less. The man had been an opium eater and a whiskey drinker both; I have cut off both the opium and whiskey and have had this to contend against, and yet the general condition of this man is better now than it was a month ago when the amputation was made, and it occurred to me that probably the reason why these patients usually improve after amputation may be, firstly, because it compels them to lead a less active life, and, secondly, perhaps, because they have less tissue to nourish, less tissue to check the growth and repair; and the question occurred to me, whether it wasn't a therapeutic measure to amputate a man's legs and arms to cure this tubercular tendency of the lung. Whether it would have this effect.

DR. SCOTT.—Looking, as I do, upon tuberculosis as a disease *sui generis*, that it is an hereditary disease, I don't believe that any amount of suppuration in a man will produce tuberculosis without an hereditary taint, or that we can point to cases in which tuberculosis has been developed in the lungs. How many of us have treated cases of suppuration which have gone on for months and even for years in which our patients have made rapid recoveries and recovered without any tubercular manifestation in the lungs at all. How many cases of fistula in ano have we all operated upon which healed without the least tuberculosis manifesting itself afterwards. If there be hereditary taint in this man which

he inherited from his father, it may develop itself at the time of this suppuration or ulceration, or it may be developed previous to that time. We know that sometimes these hereditary diseases, tuberculosis more especially, have a tendency to skip an entire generation. I have in mind an instance of this—a family of which the father was a remarkably healthy man, who lived to be over seventy-five years of age, and the mother was the same way—very healthy, yet they lost nine children by tuberculosis of the lungs. When I came to trace up the history of the family I found that the father's father died of consumption, and the mother's mother had died of consumption. The brother's children have never had it. That generation seems never to have developed it. But no amount of suppuration will ever produce a tuberculosis because tuberculosis is a specific disease, it depends upon a specific cause, and this cannot be produced. No amount of lowering of vitality will do it. Scarcity of food will not produce it, no matter how long the individual is kept on low living and under unfavorable hygienic circumstances. In the lower order of animals of which Dr. Bernays speaks of those particles of matter having been injected into the blood, those animals were selected in whom there is an hereditary taint of tubercle. We all know that in rabbits the tendency to tuberculosis is so greatly developed that under the most favorable circumstances they are liable to develop it and hence, when the disease is developed by this irritation it is the development of a disease to which they are hereditarily prone. This injection of foreign substances doesn't produce tuberculosis proper. I cannot agree with the proposition of Dr. Mudd. Neither can I agree with my friend, Dr. Porter, who divides tuberculosis into hereditary and acquired. I don't know what you mean by acquired tuberculosis. I don't believe we can acquire a tendency, an hereditary tendency to disease, nor do I believe we can acquire a tuberculosis. I believe it depends upon a specific cause.

DR. PORTER.—Why not? Is not syphilis either inherited or acquired? A tubercular tendency may certainly be inherited, that it may be acquired, I also hold.

DR. HUGHES—Undoubtedly in the vast majority of cases phthisis pulmonalis is the product of more than one generation which is not the case with every diathetic condition with which the profession is familiar. But that it must and may have a begin-

ning without a pre-existing diathetic condition, it seems to me, must be conceded from all clinical observation. These diatheses have had a beginning and their possibilities are existent in the organism, and it is extremely illogical to admit the possibility of a diathetic condition being transmitted and at the same time to deny the same organism, which is capable of transmitting it, the possibility of receiving it anew. What is there in that organism that makes it impossible for you or I to contract phthisis pulmonalis, even though we have no ancestral, hereditary transmission that gives that peculiar tendency? What is there in the clinical history of the race that leads us to conclude that those in whom the tubercular diathesis first developed must have had entailed upon them this morbid heritage which is insisted upon? It is not only true that phthisis may be engrafted anew upon an organism not hereditarily prone to its manifestation by reason of the coöperation of the causes which develop the diathesis in others; but according to the teachings of the best pathologists of the day, those who give special attention to the subject, it is now said that this diathetic condition may be transmitted by inoculation. I believe the inoculability of tubercle is now the reigning doctrine of the day; and if it be an inoculable disease, then how much more illogical is it to deny the possibility of its being engrafted anew upon an individual without the pre-existence of the diathetic tendency. Now in regard to the influence of fistulæ, ulcers and other sources of irritation on the arrest of phthisis, it cannot be denied that an ulcer or a fistula or any other drains upon the system in certain stages of their existence are a source of irritation to the organism; and it cannot be denied from observation. I apprehend, that a fistula or an ulcer of any considerable extent appearing in a person previously affected with phthisis becomes an additional source of irritation; and if practicable, these additional sources of irritation upon an organism already irritated by disease, already being exhausted by persistent morbid processes, these ulcers or these fistulæ ought to be arrested. But there is another fact which should be taken into consideration. There is a class of cases in which the healing of certain chronic ulcerations have developed afterwards, phthisis pulmonalis and this condition is known to be aggravated when the ulcerations are healed. I have seen cases where the pulmonary trouble seemed aggravated while the ulceration was healing and to be better when the sore was open, ulcerations which had persisted, which were chronic with the individual. It was only in

this class of cases that I tried to offer the explanation which I did the other night; and that is, that an ulcer to which an individual has become accustomed and which has made no perceptible inroads upon his general health is a peripheral source of irritation which is salutary in its effect upon the organism in these exceptional instances, by acting as a peripheral source of central stimulation. We make this peripheral irritation by setons, sinapisms, and by reason of a peripheral impression, make a central impression which is salutary in its effect upon the organism. I cannot now recall the name of that celebrated anatomist who went to the amphitheatre and made his best lectures under the influence of a peripheral stimulation applied by a means of a blister on his chest. If you take the irritation produced by the presence of tobacco upon the organism, a depression which in the first experience of every one, produces nausea and extreme prostration, and yet after the condition of tolerance becomes established the system becomes accustomed to the presence of the irritant it grows up to a requirement and men who begin the practice of tobacco-using in early manhood acquire what we call habit. They became so accustomed to the presence of this abnormal and morbid irritation, that it becomes, actually, a source of consolation and a source of benefit. So I think that in some cases, it is unadvisable to arrest certain sores. I would not have the gentlemen infer from that I consider it a proper course to pursue in every case of fistula, or in every case of ulceration but it seems to me it is a satisfactory explanation of those cases that seem to get worse when the peripheral irritation is stopped.

SATURDAY, Nov. 19, 1881.

**Tarnier's Forceps.**

DR. MAUGHS.—Mr. President, as I was coming to the Society to-night, I thought I would bring down a pair of Tarnier's forceps which are making some noise in the world. Possibly they have not been exhibited to the Society before. Some of the members may be interested with them, especially as there is a principle involved in their construction. They are not very complicated, and no especial skill is required in their use. There was a great deal of ingenuity in the construction of these forceps. The forceps, as you see, consist of two tractile branches, like an ordinary pair of forceps. You would scarcely know that they were not an ordinary pair of forceps but these branches are simply prehensile branches; they are not tractors. The other night at the Obstetrical Society, a doctor insisted they were intended to pull by, because they were nicely finished; but they are simply prehensors. Below them you see the tractors which are fastened by a freely movable joint near the lower portion of the fenestra, and continue in the line of the angle of the blade. Another arrangement is that the handles are bent back until they are in the line of the prolonged axis of the fenestra. They are introduced the same as the ordinary forceps, compression is made and they are fastened with the screw. They are thus permanently fastened upon the head of the child. The object of Prof. Tarnier, and one which he has accomplished, was to enable us to make traction in the axis of the plane of the pelvis. This we are enabled to do in virtue of this arrangement. The next claim of Tarnier is that they permit rotation of the head of the child, that they are freely movable, this, also is correct. Then, again, he claims that they will not slip; and you will find that this is true. After the branches have been fastened by the screw it is held as in a vice until the head is delivered. After the forceps are applied, these additional handles are applied and traction is made exclusively by these, which as you see are a continuation of the traction rods. These handles are the indicators. You see as traction is made in the axis of the plane of the pelvis, these handles will rise up and thus constantly indicate the direction of the head. It indicates very readily the point in the pelvic canal at

which the head is. The greatest objection to this forceps is, that the pressure on the head is permanent from the time that the screw is fastened until the head is delivered externally. With the ordinary long forceps we apply pressure as we make traction; that is, we imitate nature, force is exerted only during the existence of pain; when the pain ceases traction ceases. With the long forceps we loosen the handles and the circulation is allowed to go on in the cranium during the intervals. Then when we are using very great pressure with the long forceps, it is intermittent. We cannot pull without making pressure. If we make one hundred pounds pressure, that is, traction, we make perhaps, fifty pounds compression. The objection to this forceps, then, is that the compression is not taken off from the time the forceps is applied until the child is delivered; and this is not a special objection, because we need not make too great compression. The objection would only hold good where we make too great compression and continue it a great while. The traction is always made in the axis of the obstetric canal through which the head is being forced. Taken altogether, I consider it a valuable addition to the obstetric bag. We might sometimes be enabled to deliver a child with them, where we would otherwise be forced to resort to the crochet, it being impossible to deliver with the other forceps.

DR. BARRET.—One objection to them, Mr. President, is that they are exceedingly bulky, at the opening where the fenestra begins, and for that reason there would be more danger of tearing the perineum. They take a good deal of space; I don't think the fact that they clasp the head with the screw arrangement is an objection. The screw is an additional means of compression in cases where it is necessary to exert pressure; and where unusual pressure is not required, of course, it would be unnecessary to tighten the screw to a dangerous extent. The breadth between the fenestra is three inches and I should think that the thickness of the blades altogether is about a quarter of an inch, so that I should think it scarcely possible to deliver through a diameter of three and a quarter inches; that is about as small a diameter as can be delivered through with this forceps under any circumstances. But there are those who contend that they have delivered through a less diameter than that, and if the head were unusually small or unusually plastic, I presume that in certain

cases it would be possible to do it; but with this forceps it would not be possible to do it, as the forceps itself takes up a quarter of an inch of this diameter.

#### **Treatment of Tuberculosis.**

**DR. RUMBOLD.**—Two weeks ago to-night I made a statement in regard to the relation of an ulcer to a tubercular condition of the lungs that I wish to express in a little clearer manner as follows:

If an ulcer or fistula in ano, which preceded the tubercular condition of the lungs, is cured, the tubercular condition is improved; if, on the other hand, an ulcer or drain which succeeded or followed the tubercular disease, is healed, then the latter disease is made worse. I did not wish to give any theories on this subject. I merely wish to say, that this has been the result of my observation for the last ten or twelve years.

**DR. JOHNSTON.**—When I entered the profession, the books that I read taught me the doctrine which Dr. Bernays promulgated here the other evening, and it was the view held by the most learned medical men in Europe and America, viz: that particles of material were inhaled into the lungs and produced tuberculosis. I was also taught that congestion resulting from this cause, was capable of producing tuberculosis of the lungs. By referring to the works of Clark, Lewis and others, you will see it stated that particles inhaled, or any other thing producing local irritation of the lungs would, in ninety-nine cases out of a hundred, produce tuberculosis. Now, of course, this doctrine influenced the treatment, and we were told to bleed the patient, and especially, if there were hæmoptysis; if that didn't relieve it, we were taught to give small doses of tartar emetic and use plasters. Then you were taught to give anodynes, and that was the treatment that was relied upon, except a recommendation of change of climate. It was said then as now, that a change of latitude and a pleasant life would cure consumption. About 1850 the doctrine that an ingestion of larger quantities of hydro-carbons was beneficial. Then we had the doctrine advocated that the disease was due to a deficiency of blood and a derangement of the digestive organs. For the last fifteen or twenty years we have held to the use of cod-liver oil, and a change of climate. We have been reduced to these two remedies. Now when this doctrine of local irritation came up, inhalations,



which were made popular by Robert Hunter, were employed. The patient was made to inhale the fumes of burning tar; the idea being to reach the disease directly through the lungs. For the last fifteen years, I believe, inhalations have been used more or less as one mode of treatment. I believe that it is one of the best modes of treatment.

It does seem to me that cod-liver oil does nourish the tissues, and changes the corpuscles of the blood; it does tend to bring about a healthy condition of the lung, and for this reason it is a good remedy; but the trouble with this remedy is that in dyspeptics, the cause of consumption being in the digestive organs, there is not one case in twenty that will tolerate it. The hydro-carbons containing alcohol cautiously used, I think a good remedy. Outside of the diet system and the cod-liver oil, if it is tolerated, I know of no remedies which promise to cure consumption; our only additional remedies are such as relieve distressed human nature. Believing, as I do, that consumption results from deranged nutrition—whether it be hereditary or acquired—I think that if we bring the blood corpuscles up to the healthy and normal condition we may cure consumption.

DR. PORTER.—There is no disease, no condition on the face of the earth that to-day, with our luxury and hygiene, and fast living, is more important than the study of tuberculosis or, if you please phthisis. There is no disease that so threatens the human family, mentally and physically, as tuberculosis. It is a fact, sir, that in the New England States, from the record, Massachusetts, Rhode Island, Connecticut and in the Northern part of New York, there is, of every 10,000 deaths, 2,000 from phthisis, and in the Lake region from 1,400 to 2,000 out of 10,000 deaths are from phthisis. The general prevalence and the progress made in the study of the disease, render the question of its therapeutics of the greatest importance. There is no better field for study.

The treatment of phthisis ought to begin early. Many members of the profession are not careful enough in their early examinations of the patient. I mean just what I say. A patient will go a long distance to a city and receive an opinion founded upon an examination of the chest without having his chest unclothed, and sometimes with the coat on. The patient might just as well be at home. To bear out what I say, I will mention that there

is an insurance company with a considerable monetary interest in St. Louis, and in that company during September and August, the last twelve deaths of which I have any record, five were of phthisis and all those cases were examined and admitted within three years: that is, nearly fifty per cent. of deaths resulted from phthisis, and most likely in some of those cases the earlier progress of the disease had existed when they were examined. I am inclined to this opinion for the reason that I heard a prominent insurance man say to an examiner that it was not necessary to remove the vest in making an examination. How could a case of incipient phthisis, aneurism or mitral disease be detected through a vest and two shirts? I hold that it is of the first importance then in the treatment of phthisis, that we make a careful physical examination.

Secondly, when phthisis is well determined, protection of the body is necessary. In this climate it is difficult to do this; but in a case of phthisis protection means everything. It is absolutely necessary that the patient should wear sufficient clothing. There is an antipathy among many patients, and especially those who have been raised in luxury, to wearing woolen under-clothing and thick-soled shoes. The feet especially should be kept warm. A lady called at my office for me to examine her lungs, and she had on a flannel chest protector, chamois jacket, her flannels, her ordinary clothing, and a seal skin sacque. And she had been driven in her carriage from a warm store to my office. With this she had on thin, almost paper soled shoes and thread stockings. The wonder was that she escaped trouble.

Phthisis grows, flourishes most rapidly where the vitality is greatly diminished. It has been estimated that a night sweat—an ordinary night sweat is more debilitating to the patient—he loses more vitality during the process than a healthy man would during a hard day's work. It is also estimated that in a night sweat every ounce of perspiration is equal to so many pounds being carried so many miles. If there is a discharge from an ulcer and the discharge becomes greater, diminishing the vitality, it should be seen to. All abnormal leaks should be stopped.

The patient must be well nourished; if there is constipation and a thick coated tongue, it should be seen to at once. The matter of nutrition is deservedly receiving much attention.

Where there is an active progress of the disease, rest should

be enjoined. I have put patients in bed who were able to walk two miles; simply because there was a temperature of one hundred and one and a quick pulse; often from this alone the temperature goes down and the pulse is reduced. The question was asked before the society convened: What is the best climate for tubercular patients? There is one answer to that question: Every case from the beginning is an individual case, and the treatment ought to be individual treatment, and the climate suited to the patient. You will certainly not send a patient who has an incipient phthisis, where there is simply a suspicion of phthisis, to the same climate that you would send a patient who has active disease of the lung far advanced. Where there is an active secretion of pus, high temperature and quick pulse, a proper climate may be of immense advantage to him. Where patients are in the early stages, where there is little active progress, as a rule, such patients will stand a higher elevation than those in whom the disease is more advanced. In the early stages, patients require a climate in which the atmospheric pressure is lighter, and the tendency is to increase the circulation in the lung; whereas, in more active cases, in cases where there is profuse secretion et c., these high altitudes are disastrous; especially if there is a tendency to hemorrhage, the patient should seek a less elevated, dry, and even climate. In the first stages, such places as Leadville, Colorado Springs, and the Adirondacks. In the later stages, San Antonio and other southern resorts promise good results. Or, still better, lower California, or if your patient has no objection to a trans-Atlantic voyage, Algiers. I have two cases in Algiers which have done remarkably well, having recovered from what seemed to be a dying condition. Mr. President, in the treatment of phthisis by medication, it seems to me that Dr. Johnston is scarcely correct when he says that we are reduced to cod-liver oil and climate. We have much at our disposal besides. I scarcely like to go into the mention of the different therapeutic agents. Inhalation may do good in special cases; but I do not believe in inhalation as a special treatment of phthisis, nor in any special treatment of it.

DR. WESSELER.—I have had some experience in treating this disease. I certainly agree with Dr. Johnston when he says that the disease is caused by a derangement of nutrition. I do believe that phthisis is not always hereditary; it is in the most cases

acquired. In a good many cases it is produced by a depression of the nervous system; and when that derangement is such as to derange the stomach and produce dyspepsia, it deranges the nutrition and we get a calcification. Or it may occur from some other cause, lack of circulation, etc., until the lung becomes absorbed or calcified. Some lungs waste from one end and some from the other. I don't believe that the lungs always begin to waste from the top; I don't believe in filling the stomach with medicines, if no food is taken. Of course it is proper to give some little medicine, but you cannot treat this disease with medicines alone and treat it successfully. Tonics, the mineral acids, quinia and the tincture of iron occasionally, with a little morphine or opium is about the only treatment that will be of any benefit. If they are able let them walk about a little. And a little alcoholic stimulation may also be of benefit. If they are able to walk about they may take a glass of beer occasionally, or a little whiskey; too much whiskey does more harm than good. I think that all dyspeptics thrive better with a little alcoholic stimulation, but they must not take too much. A little morphine or opium, or a little sulphuric ether at bed-time makes them sleep well, and allows them to gain strength. But to give cod-liver oil deranges the stomach and only increases the dyspepsia. I think it does more harm than good. Change of climate is all right if it is done in time; but when the physician sends the patient away to die on somebody's hands, it is wrong. I believe that if the patient is at home we should make him as comfortable as possible, and not send him off to the mountains to die, as they so often do, to be sent back in a coffin. I think it is wrong to send them away from their homes, their families and their business, to cause them great expense, and the family great expense to have the body sent back. The change of climate ought to be made early, and it should be permanent and not merely for a few weeks or months. When cavities have formed the best treatment is whiskey and morphine. I think that is about as good as we can do. Cavities have been cured, I have cured some cases myself. I have cured small cavities, but when the cavities are large, the best thing you can do for the patient is to give whiskey and morphine—let him stay drunk. If the patient is satisfied, that is the best you can do for him. That certainly is the humane way to treat them. Make them as comfortable as possible and let them end their days in peace, and

don't send them to the mountains when you know they will die before they get there, or soon after. If they eat and take exercise, they don't require much medicine. A little bismuth, sulphuric acid and occasionally some Dover's powders are all that are required. This is my experience.

**DR. MULHALL.**—I think the points made by Dr. Porter, very valuable ones. In my opinion the treatment of consumption in its incurable stages is included in four words: "Encourage hygiene, avoid drugging." I mean by hygiene, reference to the food they eat, the air they breathe, the clothes they wear, the exercise they take, the company they keep and with regard to these strict, accurate and detailed instructions. If cod-liver oil, maltine or whiskey be regarded as proper additions to their ordinary diet, then advise accordingly; and so on with regard to the climate to be sought, the kind of clothes to be worn, the kind of exercise to be taken, whether Ling's gymnastics as indicated for frail chests may be advisable or not, etc. Let them avoid drugs, since they tend to enfeeble that organ on which we must so much rely for help in curing consumption, the stomach. The doctor insists upon a careful examination, with the overcoat, vest and other garments removed. When a patient comes to a physician to be examined—if he has not got phthisis—he will ask; do you think I will get it? Perhaps the family history and the personal history of the patient are more valuable even with the overcoat on, than the examination of the chest with the overcoat off, when each is weighed against the other in the incipient stage of consumption. I have examined last month I think about sixty normal chests and I don't think the normal signs—the respiratory murmur and so forth—were alike in two cases. In incipient phthisis, naturally, the signs will be very hard to discover, they will be very faintly heard. When they are unmistakable, the case is already well advanced.

With regard to protection, it is questionable whether the hardening process is not better than the hot-house process. Of course, the medium way is the golden one; but with each case you will have to lay down definite and detailed rules. With regard to climate, of course it is our chief resource; but I think that this mistake is made; we let the patient come back to see his friends. We should say to the patient; are your domestic or business relations more important to you than life? Should he

say no, then you must arrange your affairs so that you can remain where your health improves for the rest of your life, and do not come back unless for a visit of a week or two; never stay months at a time. I think this is a point that is very much offended against. A patient goes away and stays for a year, then comes back and stays a year; goes away for a year again; and this is done over and over; each visit to the place where he contracted the disease giving it a fresh impulse. The patient should be instructed to make the region that benefits him his permanent home. I generally advise them to go and engage in farming if they can possibly do it, say somewhere between Austin and San Antonio. I don't think there is any such thing as medicinal treatment of consumption. Perhaps we use the term tuberculosis when sometimes we ought not to use it. I think if we get a patient who begins to cough and expectorate, who has lost very little weight, and who has no family history of consumption; and we find over the apex of the lungs some symptoms of consolidation, we should use a mild antiphlogistic treatment with counter irritation. I know of no reason in the world why the lungs should not take on a simple, ordinary inflammatory process as well as any other organ of the body. Analogy favors such a belief. I had a case last year of a man, whom I think Dr. Porter saw with me, who had advanced laryngeal phthisis with consolidation of the right apex. His weight was 138 pounds. I introduced a seton at the back of his neck. He said it was the most satisfactory treatment he had received. His cough ceased, his expectoration ceased, his night sweats ceased and he weighs 160 pounds; but he does not live in St. Louis, he lives in the country. I think in this case the lung trouble was consequent upon the laryngeal.

DR. MAUGHS.—My friend, Dr. Johnston, has asked me to give in my experience in regard to the treatment of consumption and the changes in it. I heartily endorse the doctor's remarks in regard to the mode of treatment formerly pursued. Even since I have been practicing medicine, which is not so long as Dr. Johnston, it was still the system in vogue to a considerable extent. The patient was placed in a warm room and carefully guarded against the possibility of cold, emulsions were used, and many gave tartar emetic in the beginning; the diet was carefully selected and the antiphlogistic treatment followed. What a change

since 1850! I think the patient was scarcely ever bled if the symptoms were pronounced, plasters, setons and issues were made use of with a lowering of the diet. In the premonitory stage, at the initiation of consumption, it was common to treat it by blood-letting. With regard to the diagnosis of consumption, I think it is of the utmost importance that we make a thorough examination in all cases of supposed chest disease. With the means of diagnosis which we now possess it is possible to make a pretty correct diagnosis even in the early stages of phthisis. During the last few years our means of diagnosis have improved very much; our therapeutics has not kept pace with the advances in pathology and diagnosis. A physician should not examine a patient supposed to have chest disease with his overcoat, or any other coat on. It is utterly inexcusable; such a man would be a disgrace to his profession. Such an examination does not benefit the patient, therefore he has done the patient, as well as the profession, a gross injustice. It is impossible to guess what is the matter with a patient. You may suppose he has chest disease; his father and mother may both have died from consumption. He may die from it, or he may not. He may never have consumption at all. I have seen such cases where men have lived to an old age whose parents both died from pulmonary troubles. The vast majority of consumptives are born of parents that did not have consumption. The vast majority of those who die of consumption have acquired it; it is not necessarily hereditary. A continued bronchitis, or protracted cold excites a condition which predisposes to phthisis pulmonalis. This continued bronchitis produces consumption. I believe I was one of the first in this country to adopt the stimulating treatment of phthisis pulmonalis, and I recollect distinctly the case which led me to adopt this treatment. There was a family in our part of the country, an excellent family, all the members of which had died of consumption except a dissipated son. One of the boys was very dissipated and he was the only member of the family who survived. The neighbors said it was too bad that this drunken boy should be the only one to survive, and I concluded that the reason he didn't die was because he was a drunkard. His sisters and brothers had all died. Since then I have treated this disease with liquors. The patient should wear warm, comfortable clothing during winter, and take cod-liver oil, maltine and whiskey; I have seen much good result from this treatment. But I

think a doctor would be inexcusable if he did not make a careful examination. We need not scare our patient with the prognosis. Tell your patient he is not going to die at all, for they may not die from the disease. I remember a case, a very striking case of a very lovely woman, and very highly educated; but unfortunately her father was dissipated. I was sent for to see her late in the fall, the weather being somewhat frosty. She had a large cavity in the apex of the left lung, hectic fever and so on. I said what a pity it is that this woman can't go south, to Florida for instance, but it was out of the question. I visited her from time to time, giving morphine, cod-liver oil, lacto-phosphate of lime and soda and whiskey. She could drink only very little whiskey at a time at first, beginning with a teaspoonful. I told her to take what she could, of course not expecting it would be of much benefit, but she improved, and has continued to improve. She married three years ago and had a child, which I believe was born dead. I didn't see her then, but I saw her the other day and she was looking comparatively well; she has consumption yet, but she has improved very much. The cavities have healed up. She still has a little irritating cough and doubtless there are tubercles there yet. By all means make a careful examination of your patient; find out the exact condition. Say to your patient "My dear madam your lungs are diseased; there is a cavity here, there is a larger one there; but it doesn't follow that they are going to kill you. Don't get alarmed. Suppose you have a cavity in the lung; suppose you have consumption it need not necessarily kill you. Patients have lived 20 years with a cavity in the lung, and have then died from something else." Encourage her, build her up, place her in the most favorable hygienic condition, and give her a nutritious diet and stimulants, and your patient may not die of the consumption at all. Give your patient maltine and cod-liver oil if the stomach will bear it. I see no reason why we should not give maltine if the stomach will tolerate it. I remember a case which I treated many years ago. A prominent gentleman in the Confederate Army was afflicted with consumption. When I examined him I found that there were extensive cavities in his lungs; every morning on waking he was attacked with violent coughing and expectoration. He also had night sweats and hectic fever. When I saw him I told him his condition was serious, but that I had seen worse cases. I advised him to drink whiskey. He told



me that he had never drank any whiskey, and I believe it was true. At any rate I placed him upon cod-liver oil and whiskey. At first he could take only small quantities of whiskey; but in the course of 3 or 4 weeks he drank three pints of "pine top" whiskey in a day. He improved in health and as he got better he reduced the quantity of whiskey and drank only a quart a day. He afterwards stopped drinking whiskey altogether, and when I last saw him, was doing well.

SATURDAY, Nov. 26th, 1881.

**Pulmonary Calculi.**

DR. WESSLER.—Mr. President; I have a pathological specimen which is one of those degenerated tubercles, or pulmonary calculi. I very seldom see one of these calculi in a patient while he is alive. They are found quite frequently, I believe, in post-mortem examinations. But this man commenced to spit them out seven months before he died. By promising him an extra ration of wine, I got him to save some pieces from the sputa. It shows to what extent the degeneration may go on in the lungs, and the patient still live.

DR. RUMBOLD.—I think it was in 1872 that a gentleman called to see me at my office, for the purpose of showing me a small calcareous mass, which he had expectorated from his lungs. I have the specimen at my office now. He was then, apparently in good health. His usual weight was 175 or 180 pounds. He had lost weight but did not have much cough. He took a little cold and in recovering from this, he expectorated a hard mass, when he spat it out, it made a slight noise on the carpet. He put his foot upon it and found that it was hard, picked it up and brought it to me. I examined his lungs by auscultation and percussion, but found no evidence of disease. This man was still living in 1879, in Nashville.

DR. DICKINSON.—Was it calcareous?

DR. RUMBOLD.—I have not examined it except as I said. It looks like Dr. Wessler's specimen.

DR. HILL.—Did he have hemorrhage?

DR. RUMBOLD.—Just enough to redden the expectoration.

DR. DICKINSON.—Where the masses are nodular in character,

I think there is ground for suspicion, that in some unguarded moment, he may have inspired the article. It may have been a fragment of ossific substance. But this reminds me of a case I had some twenty years ago, of a boy, who was probably five or six years of age. He had been running about the room playing with other children, having in his mouth a buckshot which he had chewed so that it was considerably flattened. In some way, during a fit of laughter I presume, he inspired suddenly and the shot passed down into the lungs. The boy was troubled with an excessive and exhausting cough; and I think he also expectorated some blood at the time. I gave the child some treatment and the mother went home and administered it. Whether she came again before the final result or not I am not sure; but at any rate she told me that one morning she was awakened by the child who was leaning over the side of the bed and in the act of coughing. During this paroxysm he coughed something up which fell out of the mouth and striking the floor, it made a noise; on examining it she found that it was the buckshot considerably flattened. The child was relieved of all its bad symptoms and made a speedy recovery in consequence of which I received a great deal of credit that I didn't deserve.

DR. JOHNSTON.—I think these formations are found in every gland in the body. According to my observation they may occur in any of them. Every particle of bread we eat has lime in it. It is possible to have these formed in any gland.

DR. RUMBOLD.—It is pretty well known that in all these patients in which there is an expectoration of cretaceous matter, there has been a long manifestation of disease, a long continued cough, etc. It is very uncommon to have a gentleman enjoying good health in every respect, in the vigor of life—I judge he was about forty-five years old—expectorate one of these chalky lumps of matter. That is the reason I report the case. It is a very uncommon thing. I have frequently met with patients who expectorated them, but they were persons who had lung disease or tubercular deposits; but that one who is healthy should cough one of these masses up without any premonitory symptom, is unusual.

#### Nasal Calculi.

DR. ROWLAND.—The subject which has been presented to-night reminds me of a case which occurred in my practice a good many years ago. In the year 1859, I was attending a

child, the mother of which was a quite healthy lady of, perhaps twenty-eight years. While I was treating the child, the mother told me that there was something in her nose about which she had consulted a former family physician, and that he couldn't give her any satisfaction about it. Upon inquiry I found that she had been conscious that there was something there for two or three years. I immediately made an examination with such appliances as I had at hand. I dilated the nostril, and upon introducing the probe I found something that grated like bone, or stone. The next day I carried with me suitable instruments, at least such as I had, and after bathing the face with warm water I dilated the nostril with my fingers and tried to remove the foreign body. It was perfectly loose and I thought I could remove it easily, but I found that I couldn't remove it without considerable laceration, although her nostril was quite large. I broke it into two pieces, not wishing to crush it much. I wanted to get it out whole if possible, but I was compelled to break it. Altogether it measured about an inch and a quarter in length, and of irregular thickness. In removing it I produced some little laceration. I should have stated that there had been a considerable discharge of offensive matter. This ceased after the removal of the mass. It is the only case that I have ever seen. It was a calcareous deposit.

DR. DICKINSON.—Did I understand you to say that it was entirely detached?

DR. ROWLAND.—Yes, sir; entirely detached. It occupied the space of the turbinated bone, part of which was absorbed.

DR. JOHNSTON.—I must say that Dr. Rowland's case is unique. so far as my information goes, these formations are always involved in a membrane and are secreted from the blood. These formations grow by accretion, but they must be in a closed mucous surface. When they occur on a free mucous surface, and especially in the nose, the logical conclusion is that at some time or other a foreign body was brought in, and that it grew by the adherence of particles from the atmosphere.

DR. RUMBOLD.—I think Dr. Johnston's explanation is more unique than Dr. Rowland's case. I have a patient who is now living at Georgetown, Col., from whose nostrils I have taken calcareous masses. I suppose what I removed must weigh nearly

two ounces altogether. These masses are formed in the open cavity. I have seen them in the ear where there is perforation of the drum.

DR. WILLIAMS.—As the subject of stone is up, I will refer to a case which I saw some years ago in Cincinnati. A middle-aged lady in good health called at the office, with a hard round lump in the conjunctiva, which felt as if it was a bean. I examined it and found it to be a stone—the character of that they call dacryolith. It was supposed to have formed in the lachrymal gland and, to have passed through one of the efferent ducts until it lodged in the conjunctiva, and there enlarged until it got to be the size of a bean or pea. It was extremely hard and smooth. It looked as if it had undergone a marbleizing process, being hard, smooth and somewhat clear like marble. The patient was in good health otherwise.

DR. BERNAYS.—I believe I can help to explain the origin and growth of calculi on mucous surfaces, especially such as are exposed to the air. The first condition that is necessary for the growth of a stone is an abnormal condition of the mucous membrane, which is generally called catarrh or chronic inflammation, with over-secretion. Besides, we know that in the mucous membrane of the nose there are numerous mucous glands which secrete a thick mucus. Now whenever a catarrh is located in these membranes, the first thing that ensues is an over-secretion of mucus, and if this becomes chronic there may be ulceration which is accompanied, first by acid and afterwards by alkaline fermentations and then we have the conditions necessary for the deposit of calcareous matter and the formation of stone.

DR. JOHNSTON.—Am I to understand that it forms on the free mucous surface?

DR. BERNAYS.—No sir! It always seeks those parts of the cavity which are so located that it forms a little pond, in which the mucus will remain long enough to become decomposed, and in the bottom of this little cavity the calculus is formed. I don't think they can be formed unless the cavity will hold the fluid long enough to allow it to decompose.

DR. JOHNSTON.—Let us come down to the scientific question. By what process in the mucous organism do we find decomposition in the various parts give rise to these hard substances we

call calculi? The case of my friend Dr. Rowland, presented the aspect of a calculus that had formed in the nose externally to the mucous membrane. When that was up, I stated that I thought that was an impossibility. You find them on the free surface of the mucous membrane of the bladder, but they are first required to be enclosed in a sac so as to retain the lime which is excreted from the blood. About 30 years ago I was called to treat a lady for an affection of the tonsil. We found it necessary to extirpate it, and it was with the greatest difficulty that I cut through the lime formation; but it was inclosed in a sac. So it is in all these cases. These calculi may be formed in the apices of the lungs; in the lymphatic glands; in the parotid glands. If they occur in the ear they must commence in the internal ear where it could not pass out. So it may be formed in the Eustachian tube in some small sac in the mucous membrane there. I do not think they can be formed upon the free mucous membrane.

DR. RUMBOLD.—Dr. Johnston's theory, of its taking its origin from the glands, in the glandular structure inside the central mass, so that they would have to be in this shape, (illustrating), we know is not the case. There is no doubt in my mind but what it commences to take on the calcareous form in these small glands, but as soon as the gland is full, the secretion passes out along the side of it, and if these cretaceous accretions take place at all, it is from the top and not from the under side. That is proved by the fact that in the masses that I got from my patient, now living in Colorado, there are some threads in them, some hairs that were inhaled. I have examined them very carefully under the microscope. It was not nearly so regular as the limestone formation, but it was always hard to remove. It adhered to the surface very tightly, I had to remove a little to-day and a little to-morrow and so on. The removal was always painful.

DR. WILLIAMS.—I am reminded of still another case by the remarks of the gentlemen, which occurred some years ago in Cincinnati. A soldier came into our office about the close of the war; he was so loathsome in appearance that the men and women that were in the office began to run as though it were a case of small-pox. Upon examination we found that the man's mouth was completely filled with this cretaceous matter. The saliva was flowing from his mouth almost in a stream, and he

smelled so badly that we could hardly stay in the room with him. He had at the same time some trouble with his eyes for which he came to see us, but the loathsomeness of the patient prevented us from doing anything for him. We didn't examine his eyes. We examined his mouth and that was enough. There was such an intense odor that we didn't tarry long with him. Whatever became of him is more than I can say. His mouth was almost completely filled, all the little spaces above and below, were filled. The stench was so excessive that it was simply impossible to stay in the room with him any length of time.

DR. PREWITT.—The great difficulty with Dr. Johnston seems to be the formation of calculi in the nose. Now I don't see that there is any more difficulty there than elsewhere, provided the mucus that is secreted is retained. It is true that nasal calculi are comparatively rare because it is an open space and the mucus is usually gotten rid of. Whenever for any reason the mucus is retained and becomes decomposed, as Dr. Bernays says, these calculi are liable to form. Only a few days ago I made a post mortem in which there was pyelitis, which probably originated in stricture in the urethra and irritation of the bladder extending to the kidney. I found a number of these small calculi, evidently phosphatic in character. Now I have seen the whole surface of the bladder nearly covered with these phosphatic deposits, adhering to the mucous membrane. It isn't necessary, so far as I know, that they should be confined to a small cavity; it isn't necessary that they should be confined to a small crypt like a mucous follicle, in a mucous cavity, provided the mucus is retained. In these cases of chronic nasal catarrh the mucous membrane swells and forms pockets about the folds of the turbinated bone very easily and the mucus is retained and undergoes decomposition, and when the calculus is once started, unless it is dislodged and carried off, accretion goes on. It continues to grow larger and larger. We find them everywhere. We find them in the salivary ducts, in the prostatic glands, in the tonsils, and everywhere where there is a secreting mucous membrane. And as Dr. Williams says, we have this tartar forming upon the teeth in some cases. I have seen such cases where the teeth were all agglutinated together so that they were one continuous mass of this tartar; so that they formed a solid mass, the crowns of the teeth only being visible. That is a formation from the secretion of the salivary glands, and it doesn't require any closed cavity.

[Jan.,

## ARTICLE IX.

### TRI-STATE MEDICAL SOCIETY.

Taken by the JOURNAL's Stenographic Reporter.

#### FRACTURE OF THE RADIUS; TREATMENT BY RUBBER BANDAGE.\*

By EDW. BORCK, M. D. of St. Louis.

Mr. President; I have not written a paper on this subject but what I have to say in regard to the treatment of fracture of the radius I can state in a very few minutes. As I will not speak on anything except the treatment, it will be unnecessary for me to say anything about the diagnosis or repeat the experiments which have been made by me and others for the purpose of verifying how these fractures are produced, neither will I go over the long list of splints; you all are as well acquainted with them as I am. In fracture of the radius I have used all kinds of splints. The plain, the carved and the pasteboard splints, etc. etc. with more or less of good success, but I have had the best results from the use of this rubber bandage. Now the radius can be fractured at any place but we recognize generally three distinct fractures, that is, fracture of the neck, then fracture of the middle and fracture of the lower end of the radius. Take now, for instance, fracture of the middle of the radius, the biceps muscle will draw the upper end up and the pronator radii teres will draw it inwards. the lower end is also drawn downward by the pronator quadratus, Now the directions given by authors in the books is to put on a long plain splint on the inside or both inside and outside and allow it to extend below the fingers, well padded. All authors lay especial stress upon the directions that the splint must extend an inch or an inch and a half above and below the arm. Now by following this advice you will find that you may succeed in keeping the fragments from turning inwards. But when you come to look at it the next day you will find that the upper end has tilted up, simply because you left a space here; you couldn't bandage the muscles down with this splint, and the great point

\* This paper and the discussion following it form a part of the transactions of the Tri-State Medical Society which met in St. Louis, Oct. 25, 26 and 27, 1881.

is to keep the muscles relaxed or you will not be successful. You must prevent the letting up of the broken ends. Now I proceed in this way: I cut my splint the size of the arm, I would rather have it a little smaller than a little too large. I pad this well and use the rubber bandage. Sometimes I use a strong single bandages in the lower part, like a bracelet, and the thin rubber bandage for the other fractures especially when there is much swelling. I find this a very nice, easy plan and I have obtained good results from it in fractures specially of the lower end of the radius. In dressing it I simply use the rubber bandage. If the thin rubber bandage, I make three or four turns and put a little cotton in first. I look at it every day. You would be surprised to see how nicely this bandage keeps the fragments in place. No contrivance that I have ever used has given me so much satisfaction at this simple mode. I did intend to have some of my patients here but one didn't come and the others sent excuses. Now I do not always carve the thumb out as you see on this splint, sometimes I leave that off. I do not bandage the thumb either. I merely put this thumb for the patient to have a guide, in these fractures; I think it is unnecessary. I never do it. I simply make one loose turn and that is all. I have had better results by this method than any other. Now in using the plaster of Paris or pasteboard splint I believe surgeons invariably put them on the under side and turn them up. I have used them in that manner too, but lately I have never used them in that way. When I have been compelled or desired to use the plaster splint I put it on from above. I have my assistant hold the hand and the first thing I do is to teach and to instruct my patient to keep his arm perfectly relaxed. Thus, if you instruct your patient he can assist greatly in the treatment of the fracture. When the muscles are relaxed there is not so much trouble to keep the fragments in place.

DR. BOOTH, of Sparta, Ill.—I would like to ask the Doctor to explain one thing. When your splint is not so wide as the forearm, it strikes me that you would destroy the intercostal space and prevent the separation of the bones, and consequently prevent pronation taking place afterwards. I have been in the habit of dressing fractures involving the forearm, either one or both bones of the forearm by a broader splint to prevent the chance of compression. I have used the pistol shaped, ordinary



splint in Barton's fracture or difficulty involving the joint. I think it is very important in order to preserve the interosseous space to have the splint wider than the arm so that you can have no pressure on either one of the bones.

DR. BORCK.—In reply I will say that I pad my splint well. I don't see why the splint need extend above the arm. You can put on enough padding to keep the bones apart. If you desire, you can do that without having the bone enlarged. My object is to prevent the tilting of the bone either at the lower or upper end. Keep the bone in apposition, and the interosseous space takes care of itself, and in the lower end of that bone, you have no interosseous space to trouble you. I have treated these cases in this manner with success. Of course it is necessary to get used to this method. One surgeon will apply one kind of splint much better than he will another, because he is accustomed to apply it.

DR. BOOTH.—I would like to ask Dr. Borck if he would adopt this method of treatment in fractures of the lower extremities?

DR. BORCK.—I can use the rubber bandage very well in some cases of fracture of the lower extremities. If I were treating a fracture of the tibia, where we have tilting, I certainly would prefer to have one splint on the inside molded to the shape of the leg and treat it in the same manner as I do the arm.

DR. BOOTH.—Mold it to the shape of the leg?

DR. BORCK.—Precisely.

DR. OWENS, of Evansville, Ind.—I would like to have the question of Dr. Prince, of Ill. discussed. The question was as to the necessity of quiet in a fractured limb. Whether it is necessary or advisable to keep a fractured limb perfectly quiet. I would like to hear more on that subject, as I am very much interested in it.

DR. FAIRBROTHER, of East St. Louis.—I would like to inquire what is new about Dr. Borck's splint? It is the rubber bandage I suppose. We all use it more or less. It is the old fracture splint. The question is the advantages and disadvantages of the use of rubber bandages. The advantage of the rubber bandage, if there is any, over the cotton bandage is that you don't have to see it so often, it holds its position longer; but, according to

Dr. Borck, it is necessary to dress the patient every day, and that will make too big a bill. In an ordinary case of fracture of a child's leg or arm, we do not go to see him every day, but let him come to the office a half dozen times from the time the fracture takes place until it is healed. It is usual to use the common cotton bandage and a splint like that Dr. Borck has shown. There is an accident of frequent occurrence in fractures of the radius; that is a partial dislocation or a complete dislocation of the ulna of which Dr. Byrd or Dr. Buck have spoken. So far as I have been able to observe among hospitals and surgical cases, the old pistol shaped splint is not used in these cases. It is out of date. It is said its tendency, instead of preventing the dislocation of the ulna increases it, increases the danger, so that the usual straight splint has been adopted in the place of the pistol shaped splint and the cotton bandage is used, the cotton being well padded upon the shingle, answers every practical purpose. It is not necessary, except in rare cases, to undo it, or change or lighten it for a week after fracture.

DR. D. PRINCE, of Jacksonville, Ill.—Mr. President, I suppose this pistol shaped splint just referred to, was introduced for the purpose of overlapping the short fragment of the radius on the long fragment in Colle's fracture, the idea being to make the ulna the fulcrum of pressure, the end being adducted in the anatomical position to prevent the short fragment overlapping the greater. I think the credit is due to Dr. Moore of Rochester, N. Y., of having discovered that there is frequently a displacement of the flexor carpi tendon from its natural position, the posterior position so that the lower end of the ulna is made to take place behind this pushing the ulna forward and as the ulna is pushed forward any pressure by a posterior splint makes it worse, makes the case worse. It prevents the possible replacement of it into its proper groove, so that the deformity is made worse. The ulna projecting forward makes it prominent where it should not be. Dr. Moore, reasoning upon his anatomical discovery, adopted a plan of treatment which consisted simply in placing a small roll—a bandage rolled up in this way—upon the ulna. The fragments are reduced and brought into position to the best possible extent and then this compress is placed upon the anterior surface of the ulna and it is retained by pieces of plaster. Dr. Moore in the enthusiasm of his discovery,

did nothing more but simply directed that the arm be carried in a sling; but in carrying out Dr. Moore's plan, I have found it convenient to use a short splint, a splint extending from the elbow to the distal part of the carpus leaving the fingers and thumb free to movement. It is five or six years since I first observed this dislocation of the tendon, it may be called a dislocation, the tendon is displaced backwards and the ulna is displaced forward. It is a change of location between the ulna and this flexor carpi tendon which passes the groove at the outer anterior portion. The ulna is displaced. Now this compress is intended to keep the ulna crowded back and favor retention of the tendon in its proper groove. I have a short splint which I use and I think it is better than the compress alone. If the compress is simply bandaged around the limb, the bandage must be tighter than is necessary if a splint is employed.

DR. FERREL.—is it possible to recognize the change of place between the tendon and the bone?

DR. PRINCE.—Now it is probable that a section in this case would show that the extensor carpi muscles help to push the ulna forwards. Now when the compress is put upon the ulna, of course it pushes the ulna back. After having this reduced to his satisfaction, Dr. Moore puts on a piece of pasteboard as a compress to keep it from sliding away.

DR. BOOTH, of Sparta, Ill.—Would it not be better to put the compress behind and throw the carpus forward? Is it not better to place the compress behind the carpal bones and throw them forward? The ulna is fixed so far as the upper portion is concerned. It is the radius that articulates with these bones—the ulna with the intra-articular fibrous cartilage.

DR. PRINCE, of Jacksonville, Ill.—We usually drive the horse not the cart. The carpus is entirely indirectly connected with the ulna. The ulna pushes the carpus forwards so as to twist the lower fragment. The compress pushing the ulna backwards changes its relation to the carpus without any pressure on the carpus itself. I am fully conversant with Dr. Moore's theory, I think, and the practice has resulted much more satisfactorily than the former—the overlapping of the lower fragment of the radius and the overcoming of that overlapping. I am fully convinced that as soon as Dr. Moore's theory becomes generally

known, his practice will be generally adopted. In regard to the use of the rubber bandage, I have nothing to say in addition to the criticism that has been made.

DR. OWEN.—I would like to hear Dr. Prince state his impressions as to whether the fractured parts should be kept perfectly quiet, or allow them to move?

DR. PRINCE.—I have answered that question and I think his answer will suggest itself to everybody at once. You see a sheep running about the pasture with a leg fractured, and if you watch the progress of union in the injury you find that at the portion where there is the greatest amount of motion, there is a liberal exudation thrown out around the fracture; it serves as a nidus for bony deposit, producing a deposit of callus of a very considerable size where there is a good deal of motion. Now in a human subject where there is very little motion you see a very small amount of provisional callus deposited, while the surfaces of bone, if in contact will be cemented together in both cases. Now I say this, if a liberal exudation be encouraged, a larger amount of provisional callus is given out—deposited—and it is very easy to avoid movements afterwards; whereas, if the parts are kept immobile and bandaged this exudation is discouraged and may exist only in the smallest possible amount. Now I have nothing to tell you that has been worked out by actual experience. I present this for whatever it is worth. There is another thing that many surgeons have an enormous idea about, regarding it as absolutely necessary to keep the part absolutely quiet. At first he is apt to labor under the impression that the tighter he bandages the limb, the better it will result.

DR. HILL, of Bloomington Ill.—I am a little surprised at the remarks of the gentlemen that have had a great deal of experience in treating these fractures that it is necessary to dress and examine the broken fragments every day. I think it meddlesome practice to examine a fracture every day or even once a week. I have been in the habit of reducing a fracture, putting it in position and keeping it in position at rest and before the callus has become hardened—in the course of the ninth or tenth day, I have removed the dressing and examined to see that the bones were in apposition, then the limbs were done up with the permanent dressing, and that is all the dressing that is required. I have seen physicians before now who made it a habit to go and exam-

ine a fracture every day and I regard it as a meddlesome practice. You can't go to work and remove the bandage every day or every few days, for that matter without disturbing the fractured fragments of bone. I would not expect good results from such work. If a bone is put into position and the bandages are applied and then the bandages become too tight, then of course it is necessary to loosen and readjust them; or if the bandage becomes too loose on account of the subsidence of the swelling, it is necessary to tighten it, but otherwise I would not undo it until the eighth or ninth day, and I would then put on the permanent dressing and the arm or broken bone should then be kept at rest for three or four weeks at least.

For setting fractures of the forearm there are a great many apparatuses in use. I oppose the use of plaster of Paris for the very same reason that I should object to the rubber bandage: from the very fact that you are liable to make pressure so as to force the fragments down into the inter osseous space and thus destroy rotation. I find that the immobile apparatus is very useful.

DR. JOHNSTON, of St. Louis.—In regard to the question asked Dr. Prince as to the necessity of keeping a broken limb immobile, I would answer that according to physiology, it should be kept perfectly quiet, and such medical appliances made as to prevent excessive reaction and to prevent septic matter being thrown out, so you should keep the parts as near the normal condition as possible; so that every surgeon, I presume, aims to keep the limb as quiet as possible until the injury to the soft parts heals, the irritation subsides and the exudation is thrown out, that he might bring about action so as to cause absorption of the exudation and plastic matter be thrown out. I think it is a plain physiological proposition that the parts should be kept quiet until the inflamed state and the reaction subsides.

DR. BORCK.—In answer to my friend, Dr. Fairbrother, I will say that he is mistaken if he understood me to say that I examined and dressed the fractured parts every day because the rubber bandage was applied. I didn't say that. I say you should look after the fracture every day, but don't remove the splint. I didn't say you must remove the splint, as the other gentleman, Dr. Hill, understood me. I do not advocate such a proceeding at all. I do say you should look at the fracture every day. So far

as the question of the fee is concerned, that doesn't belong to the treatment at all—not a particle of it. If a surgeon takes upon himself the responsibility of treating a fracture, no matter where, he should not stop to think about the fee—one hundred fees would not pay for a deformed limb. If he doesn't look at it for eight or nine days, and always has a good result, he is more lucky than many others have been. He may find he has made a mistake and a deformity may result. I advise you to look at your fracture every day, and if you do not wish to treat the fracture and spend the time, send the patient to some one who will. In reference to the pistol shaped splint, I think it is unnecessary. The straight splint is just as good in many cases.

DR. HILL.—Perhaps I have misunderstood the gentleman. I understood him to say, "I remove the bandage and examine the fracture every day."

DR. BUCK, of Springfield, Ill.—I want to occupy a single moment in referring to the discussion of the physiological process going on in the course of the repair of fractured bones, and I may be able to assist in settling this question. There was a time, when it was considered necessary, at least by the laity, and some of them have the impression yet, that they have to bear pain, that the parts must swell up and cause pain in order to effect a cure, and I believe that a certain amount of irritation is necessary to provide the material which is to unite the fragments. Dr. Johnston in his remarks, insisted on keeping the parts as near the normal condition as possible; now I imagine there would be no curative change if the bones were kept in a perfectly normal condition. Dr. Prince, on the other hand, thinks that in some cases at least so far from keeping them quiet, a mild irritation stimulates them to throw out reparative material. It strikes me that Dr. Prince may be right in his ideas.

DR. REBER, of Shelbyville, Ill.—I wish to say a few words in regard to the point of the advisability of complete immobility, whether it ought to be secured. The question is, whether you can maintain complete coaptation without securing complete immobility. The probability is, that it would not be safe to allow the idea to go forth, that it was not necessary to secure complete immobility in the fragments of a fractured bone.

## Reports from Hospital Practice.

### ARTICLE X.

DISPENSARY OF THE MISSOURI MEDICAL COLLEGE, ST. LOUIS, MO.  
SERVICE OF JAMES P. KINGSLEY, M. D. Reported by ELMER  
L. LEGGE, A. M.

**INFANTILE PARALYSIS OF BOTH LOWER EXTREMITIES.**—Walter W.—æ. two years, was first seen Dec. 2. Child well nourished, general health good; absence of hereditary predisposition to neurotic diseases; no history of previous injury or disease of serious character; hygienic influences surrounding child, malarial; besides residing in a malarious part of the city, the floor of the living room of the family rested on low ground.

During August of last year, the child was taken on a long journey across the city, walking several miles through the dusty streets, and with the thermometer ranging over one hundred degrees Fahr. Weary and altogether tired out, upon returning home late in the evening, the mother bathed the child in a tub of cold water. During that night the child was seized with a high fever, which continued for three days, after which was noticed some loss of muscular contractility and power of motion in right lower extremity, followed later by muscular atrophy of that extremity. The fever subsided at the end of three days and did not come on again. Sensibility remained unimpaired in every part of the limb, with the loss of power of movement at no time complete, however very nearly so. Three weeks after loss of power was detected in right lower extremity, a corresponding loss of muscular contractility suddenly appeared in the left lower extremity.

When mother first presented child at the clinic, she stated that he had not walked since the paralysis was observed in September. The lower extremities were from one to three degrees lower in temperature than the upper corresponding extremities; the right lower extremity having a lower temperature than the

left, as well as a greater loss of muscular power. In no other part of the body was there manifested any symptoms of neuroses. The general state of digestion not impaired, appetite keen, condition of bowels normal, complained of no pain at any time.

Treatment, electrical and mechanical, no medicine given until recently, then Fowler's solution.

Gradual improvement, functions of left lower extremity more rapidly regained than of the other limb. The child is now almost cured.

It might possibly be of some passing interest to mention here that which may seem strange enough, a mistaken diagnosis. The mother stated that before coming to the "Missouri Clinic," the child had been examined by a surgeon and the loss of power in the extremities diagnosticated as being due to disease of the hip-joint.

**DIABETES MELLITUS.**—Mary C.—æt. sixteen, never having menstruated, tall, delicate girl, was presented for treatment during the first week in October, 1881. The mother's history of the child antecedent to present disease was obscure, and and that given relating to the present disease, not satisfactory.

Father and mother healthy, other members of the family strong and robust, no phthisis or epilepsy known in family stock. The girl has been sick for nearly three years, presumably with disease, seen and prescribed for by several physicians, no two prescribing the same course of treatment; just what plan of treatment was selected by the individual physicians, is not certainly known.

The exciting cause is probably exposure, presumably the excessive use of saccharine articles of food, associated with some low form of febrile disease. The symptoms come on gradually, the disease not being discovered for months after its onset. The first suspicion that the patient was going wrong, was excited by a large increase in the urinary secretion, the girl rising many times during the night to void the urine. Failing strength and rapid loss of flesh followed in quick succession, attended by an excessive and increasing appetite, and insatiable thirst. Further loss of flesh and strength until patient became sadly emaciated; digestion deranged, bowels constipated and mind depressed.

When patient first came to clinic, she was much emaciated, discouraged, and saddened. Previous to this time no attention had been directed to the selection of proper food and hygienic



surroundings. She was passing urine in large quantities, of a specific gravity of 1034, very sweet to the taste, the known test of sugar, showing the proportion of sugar to be large. The breath was intolerable, tongue clear and flabby, gastric disturbance, flatulence. Eye-sight affected.

The child insists that she is going to get well, at any rate, many of the distressing symptoms have yielded to treatment. She is cheerful, good natured, hopeful, eats more moderately, drinks less water, voids less urine and none at night, however, specific gravity remains unchanged (1034).

Treatment, all food containing sugar, or articles convertible into it, (bread, potatoes, rice and tapioca, and such vegetables as turnips, cabbage, carrots, peas, and indeed all foods rich in starch,) were strictly forbidden to be eaten. Animal food of any kind, broths and soups, eggs, cheese and cream with gluten bread and biscuit was directed for the patient. The patient was allowed to drink no more water than enough to allay thirst. Exercise in open air. Medicine given, fluid extract of ergot, twenty minims three times a day during October and November. In December, lactic acid was substituted for the ergot, in doses of twenty minims, three times a day after meals. Child growing on to improve.

## Reports on Recent Progress in Medicine.

## ARTICLE XI.

REPORTS ON DERMATOLOGY. By R. W. WILCOX, M. D.

**THE MASK TREATMENT OF ECZEMA.**—Eczema of the face and head so common in children, in many cases fails to be relieved for the simple reason that the applications are not closely applied to the diseased surface. To remedy this deficiency a mask is here in use, a piece of cloth with holes for the eyes, nose and mouth, with slits for the ears to assist in keeping it in position. The ointment is to be thickly smeared over the mask and it is to be worn constantly, only being removed as lotions are applied. At the outset, the mother's pride is wounded, but after a few days the benefit is so apparent that the objection is no longer made. This treatment effectually prevents the scratching which so thoroughly thwarts all endeavors. Of course any ointment can be used, but for the most part, Diachylon, very carefully made, is selected. As material for the mask one sees how ordinary coarse flannel, which it seems would be objectionable on account of the heat being retained, but there appears to be no objection to the use of ordinary muslin. In something the same way a skull-cap can be made, the inside of which smeared with the ointment, can be used for eczema of the head.

**LEITER'S HEAT REGULATOR.**—Under this name is known an apparatus which meets with much favor, not only in the skin wards, but as well in other departments. It consists of a flexible metallic tube of small diameter (one half centimeter) of any convenient length, say two meters, doubled on itself and then coiled after the manner of a watch spring, as round, oblong, square or rectangular in form, the adjacent turns being held together by extensible tapes. Rubber tubes a meter or so long, are attached to the two open ends, and these have ordinary lead sinkers for retaining the ends in the water-containing vessels.

This completes the ordinary apparatus, but the more elaborate forms are fitted with a thermometer and lamp, with a reservoir containing a tube coiled as in a still, in the course of the circuit. To use this apparatus it is necessary to have a reservoir of water at a little elevation and a receiving vessel at a lower position than the part whose temperature is to be regulated. Then adapt the apparatus to the part, insert the tubes into the respective vessels of water, and start the siphon. When the upper vessel is nearly empty, by reversing the places of the vessels, the flow is continued. The temperature of a part can be regulated as far as it is possible to regulate it, by external agencies, without disturbing the patient, and without wetting the clothing, or the bed. By this plan, either dry heat or dry cold can be applied in what seems to be a satisfactory manner. One objection suggests itself that the weight of the apparatus on a diseased surface might be painful to the patient.

**INITIAL LESION ON LIP.**—Considering the rarity of this, it seems well to record this one case. Patient, a man about 35 years old, without any history, not a smoker, presented himself with an induration of the lower lip extending from the middle line nearly to the left commissure. The glands in the submaxillary region of that side slightly hard, cervical and other glands normal. The induration presented a denuded surface about a half centimeter in diameter near the mucous border of the lip which discharges a small amount of thin sanious matter; the duration of the induration was about five weeks. Being given some simple remedy, he presented himself at the expiration of a week with a beautiful roseola on chest and abdomen, thus establishing a diagnosis to which the peculiar induration pointed.

**LOUSE DISEASE.**—It is hardly possible for an American to imagine the formidable looking results that come from the presence of a simple parasite. Filth and lack of care often coupled with cachectic conditions gives, to a stranger, anything but a favorable prognosis. But the thorough application of petroleum, rest and good hospital care at end of a fortnight renders the improvement so marked that the patient is hardly recognizable.

**SCABIES.**—The first impulse of the Dermatologists have, when an apparently unexplainable or obscure eruption presents itself, is to examine the inter-digital spaces and the flexor aspect of

the wrist and forearm. The percentage of successes in finding well marked burrows is somewhat astonishing. One of the diversions of the clinic is to have some six or more men and boys in line, stripped; let each take a portion of Vlemineckx's or Unguentum Wilkinsoni in their palms and rub it in on corresponding portions of the body in concert. After all the accessible portions are covered, then standing in file, each anoints the back of the man standing in front. After the first and last man have had their private seance, the operation is complete. Generally one application is sufficient, care being taken in regard to the clothes.

**PRURIGO.**—Another novelty is the number of cases of Prurigo seen here. At first the diagnosis did not at all appear clear, but the following points are here considered. Prurigo is here distinguished from scabies, in that the genitals remain free, no burrows are to be found, its duration from early childhood and the highest manifestations are on the legs. From simple Pruritus cutaneous by the infiltration of the skin and absence of any such general condition as Diabetes, Eczema chronicum universale is the diagnosis that most of the cases would suggest that the manifestations on the flexors of the joints and on the genitals would serve to exclude Prurigo. If both diseases be combined, all that the authorities here say, is "one must first treat the eczema." Ichthyosis would be excluded by the presence of excoriations the results of pediculi vestimentorum by the most marked manifestations on the shoulders and loins and the excoriations would be longitudinal. The treatment commonly seen here is a thorough inunction of Vlemineckx's solution, and then a warm bath for three or four hours twice daily. Another treatment is painting with tar and then the bath. In the majority of cases, general treatment is demanded. In the cases seen, a mask treatment makes a great improvement in the appearance of the skin, the condition of the patients and the amount of itching.

**LUPUS.**—Several cases seen here, have been treated by simply scratching out the diseased tissues with a Volkman's sharp spoon, the places of erosion being covered in the interval by some simple ointment spread on a bit of muslin. The comparative painlessness of the operation, when the general failure of drugs and

the uselessness of excision is considered, seems to mark this as the best treatment.

**ACNE.**—No addition to the medical treatment has been presented, but in the Clinic is seen a new instrument for removing collections of pus as well as comedones in that form which originally was a seborrhœa. The watch key so often recommended is painful, and can not always be successfully used on that account. Later the improved watch key suggested by Kaposi, which was simply a watch key on a large scale, but the rim made broader, so that it would not cut in so deeply. The present instrument is an ordinary Volkman's spoon with a small perforation at the lowest point in the bowl, and this perforation having its edges carefully rounded off. The advantages being that the point of application can be perfectly adjusted, the perforation does not detract from its other uses and the pressure being diffused over a larger area, less pain is caused.

**BATHS.**—Under prurigo was mentioned the fact of baths holding an important place in the treatment. Generally prurigo, psoriasis, eczema and burns are the only diseases treated in this manner. Of course many desired medicaments can be added, but as the experiments show, some with doubtful advantage. In eczema one finds more in the books, than in actual use at the Clinic. The other exponent of the water treatment, is the water bed, in which a patient remains almost constantly, the water being changed every six hours. A few cases of general psoriasis seen under this treatment in ten days the infiltration became markedly less, the scales were thoroughly macerated, and color became almost normal. It is claimed that the best effects are seen in burns of moderate severity, the advantages are, the pus being constantly removed, the necessity of changing the dressing being done away with, and the cicatrix is said to be more extensible.

**NAPHTHA.**—One of the latest additions to the pharmacopœia of Dermatology, is naphtha. At present it is being quite extensively used in psoriasis and other scaly eruptions. At this time but little can be said of its actual value, but many claims are made for it.

Vienna, Oct., 1881.

## Clinical Reports from Private Practice.

### ARTICLE XII.

CONGENITAL ABSENCE OF ANUS AND RECTUM.—FISTULOUS COMMUNICATIONS BETWEEN RECTUM AND VAGINA. By ROBT. C. WATERS, M. D., of Perryville, Mo.

On July 19, 1880, I was requested by Dr. W. P. Newman to visit with him, an infant, the subject of a congenital deformity. The child was of a sanguineous temperament and evidently very large and healthy looking for its age—only five days. Upon examination we found we had to deal with congenital absence of the anus and upon further examination, fistulous communication between the rectum and vagina, through which the fæces passed quite freely. The rectum terminated in a *cul de sac*, and the recto-vaginal fistula was situated probably one-half inch above the lower portion of this *cul de sac*. The vaginal terminus of this fistula alternately contracted and relaxed after defecation, very similar to that of the sphincter ani after an ordinary evacuation. By means of a bent probe we estimated the deficiency of the rectum or the space filled with connective tissue between the rectal terminus and the anus, to be about one-half an inch. knowing the tendency to callosity which exists in all fistulæ, I advised immediate operation as offering the best chances for turning the fæces into their normal channel, and thinking it would obviate the necessity for closing the recto-vaginal fistula, by present or future operation. Accordingly we selected Saturday, July 24, for performing the operation. We deemed it best not to administer anæsthetic both on account of the minority of the patient and operation. I introduced a combined grooved director and aneurism needle, as a guide, into the *cul de sac*, and gave it to an assistant. Selecting a suitable bistoury, I divided the integument through the median raphe and endeavored to tear the tissues with a scalpel handle, but found that they could not be torn, consequently I divided them with the bistoury. I easily succeeded in reach-

ing my guide, and introducing a probe-pointed bistoury, I enlarged the opening to what I thought sufficient. My first division of tissues, however, gave rise to a considerable hemorrhage, which I now found I could not check so easily. I could not succeed in catching the vessels, although sure the hemorrhage was arterial. I tried cold and then compression, and failing, I introduced a tampon saturated with Monsel's solution and placed simple cotton on top of it. By this means I arrested the hemorrhage. I directed the parents to let the child alone until I could see it again, and not to remove the tampon by any means. We called again July 26, and found tampon had been passed and with it fecal matter. I now (following the injunction of Erichsen) tried to draw down the rectal mucous membrane and fasten it to the integumentary margin of the anus but could not. I could not even tear it loose with the scalpel and did not fancy the dissecting in this region on account of the previous hemorrhage. Consequently, I concluded to let it alone and use dilations by an improvised dilator, using the rubber case of a clinical thermometer to begin with. This part of the operation I entrusted to a maternal grandmother in the absence of a more suitable person. The patient being twenty-two miles away, we could not give the case the attention it would have been given if it had been nearer to us. The dilatations were continued daily for about two weeks, and everything seemed to be progressing nicely, when the mother concluded that it gave the little babe too much pain and discontinued them. As a matter of fact, the artificial channel degenerated into a fistulous canal which eventually closed entirely and the feces passed through their previous channel. However, through the two weeks and probably a month longer, the feces continued to pass through the artificial channel. Of the cause of this peculiar mal-formation, we know but little, yet experimentation upon the lower orders of creation has enabled physiologists to give us an explanation somewhat satisfactory. For instance, we know that the rectum is developed from the external blastodermic membrane and that the large intestine, stomach etc. is developed from the internal blastodermic membrane; that the large intestine and genito-urinary system in primitive life terminate in the umbilical vesicle. That no anus exists, for a septum is placed between the anus and rectum and the rest of the large intestine; and that persistence of this septum gives rise to one of the most common forms of this peculiar congenital deformity,

known as congenital closure of the anus (Erichsen). Now from the premises to the conclusion is but a short step. Evidently the communication between the intestine and the genito-urinary organs persisted and the septum was not absorbed. The non-absorption of the septum caused the lower portion of the rectum and the anus not to be formed. The pent up fæces sometimes finds an exit through the bladder, but evidently this only occurs when the absence of the rectum amounts to some two or three inches. Erichsen says that hemorrhage in the performance of this operation, usually proceeds from the inferior hemorrhoidal vessels. In my case it evidently came from them. He likewise states that unless you bring down the mucous membrane, the operation will fail on account of the fistulous degeneration of the canal. I did not want to use Monsel's solution in this case on account of its defeating my ultimate object, viz., bringing down the mucous membrane. This fistulous degeneration is partially proven in my case, but not entirely. However, it would probably have occurred upon the cessation of dilatation. After the operation the little patient suffered from shock, but rallied and doing well, in spite of the the gloomy prognosis of a number of ancient, "gross-mutters."

I am informed by Dr. Newman that the little girl died during the past summer, from cholera infantum.



[Jan.,

## Periscope.

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### ARTICLE XIII.

#### MATERIA MEDICA AND TOXICOLOGY.

**REPORT ON YERBA SANTA—ITS THERAPEUTIC USES.**—Within the last two or three years there have been brought to the notice of the medical profession a large number of new remedies, many of which, it is true, are worthless, but among the long list we find a few which merit our consideration. One of these, to which I desire to direct your attention this evening, is Yerba Santa, or *Eriobyction Californicum*, which has proved, in my hands, a valuable therapeutic agent.

The fluid extract of the leaves is, I believe, the only preparation in the market, the dose of which is from ten minims to one drachm.

As a remedy in all forms of acute inflammation of the air passages it is useful. It may be used alone in solution with glycerine, or in combination with expectorants or anodynes. I prefer the former method of administration, as glycerine is the best vehicle, and makes a better solution than syrups or water, both of which precipitate the gummy portion of the preparation.

Its mode of action I am not prepared to assert positively, but am of the opinion, from my observation of its effects, that it acts specifically upon the mucous membranes of the air passages as an astringent. Further observation of the effects of the drug will doubtless demonstrate its physiological action.

It is not my purpose to enter into an elaboration of theories or facts, but simply to bring to your notice the types of cases in which I have found the drug prove beneficial, by citing one case of each type, which will serve as examples, and demonstrate the classes of cases in which it may be used.

#### I.—*Acute Bronchitis.*

Mrs. M., aged 30, has been subject to one or more attacks of bronchitis every winter. The attacks have invariably been very

severe in character, with much bronchial irritation and incessant harassing cough, to such an extent as to prevent sleep either night or day. The acute stage of the attacks would usually last six or seven days, in spite of all the orthodox remedies, and it would be three or four weeks before the cough finally ceased.

I was called to see her one day, at about 3, p. m., suffering from an acute attack of bronchitis, which had begun the night previous. Cough was incessant, and substernal distress very great. Having in view my former experience in her case with different remedies, I concluded to try the Yerba Santa.

I therefore prescribed the remedy in half drachm doses of the fluid extract, to be taken every three hours. Three doses were taken before bed-time. After the first dose, the cough was ameliorated, and upon taking the third, she went to bed and slept without awaking the entire night.

She continued the medicine the two following days, and was entirely relieved. My attention was arrested by the rapidity with which the acute inflammation of the bronchial tubes was controlled. There was no second stage; no secretion of mucus after the first few doses. The attack appeared to have been aborted.

I have used the remedy since then in a number of cases of acute bronchitis, and always with a favorable result.

## 2.—*Laryngismus Stridulus.*

A child eight years of age is subject to repeated attacks of bronchitis every winter. Upon the advent of the inflammation, as is frequently the case with delicate children, this child after going to bed at night, would be invariably seized with an attack of laryngismus stridulus.

Having been called to see her in the beginning of an attack of bronchitis, I prescribed the Yerba Santa in ten minim doses every three hours. The cough was modified, and she passed through the attack without having experienced the distressing laryngismus.

This case directed my attention to a new use for the drug, and since then I have used it in several similar cases as a prophylactic. A dose of the remedy administered at bed-time to children subject to spasm of the glottis, was never followed by an attack.

Whether this was *post hoc* or *propter hoc* may be questioned,

but, from the uniformity of my experience, I am of the opinion that the freedom from attacks was due to the remedy.

### 3.—*Bronchorrhæa.*

I was asked to see an infant, aged 2 years, affected with a bronchitis of several weeks' duration, with profuse secretion of mucus, which, owing to the child's age, blocked up the air passages and seriously interfered with respiration. Was informed that the usual remedies had been given without producing any result. Ordered Fl. Ext. Yerba Santa in five minim doses, three times daily. In four days the profuse secretion was entirely arrested and the child rapidly recovered.

In adults, as well as in children, I have witnessed its beneficial effects in arresting bronchorrhæa.

4. The cough of measles I have often seen relieved by this drug. It is more palatable to a child than the orthodox remedies, and as it does not disturb the stomach is much more desirable.

Thus, gentlemen, I have, without wearying you with details, briefly outlined the types of cases in which Yerba Santa has proved useful in my hands, leaving you to judge whether it may prove as beneficial under your administration, and to decide upon its value as a therapeutic agent.

To summarize, we may say that Yerba Santa will rapidly relieve acute bronchitis, is a prophylactic for laryngismus stridulus, will arrest profuse secretion of mucus in chronic as well as acute bronchitis, and is useful in allaying the cough of measles.

As to its use in chronic bronchitis my success has not been so uniform. Although relieving some cases, in the majority, after giving it a fair trial; I was compelled to abandon its use and resort to other remedies.

I never find larger doses than one-half fluid drachm necessary, although it may be given in much larger doses without producing any ill result.—[*New Orleans. Med. and Surg. Journal.*

**METHOD OF USING ELECTRICITY IN DIPHTHERIA.**—Dr. G. K. Smith (*Proceedings of King's County Med. Soc.*, Aug. 1881), states that he has employed electricity with great advantage in diphtheria. His method is this. He places the feet of the patient in a bath of water as hot as it can be borne with comfort,

and he puts in that water one, two or three tablespoofuls of saleratus. He then takes a glass of cold water and puts some saleratus in it, and with this solution wets the electrode which is to be applied to the throat. The negative pole of the battery is put into the bath in which the feet are placed. The positive is to be covered with cotton and used in the throat, on the tongue, and in the nose if it be needed there. Of course the sponge-handles or ordinary electrodes cannot be used in these localities; but a very convenient one for the mouth and throat is made by covering the blade of a dinner knife with a thin layer of cotton, which is to be soaked with the solution of saleratus. The cotton also serves to keep the soft parts of the mouth and throat from direct contact with the metal which otherwise would cause pain. The mouth should be kept open, so that the teeth will not touch the electrode. A convenient electrode for the nose is made by winding a thin layer of cotton on a wire. Thus prepared, the patient is seated in a chair, if able to sit up. The feet are placed in the bath, and the patient holds in his lap a basin to catch the saliva as it flows from the mouth, or as he has occasion to spit it out. The physician should be careful not to sit in front of the patient, for fear that the patient will cough and blow his poisonous secretions in his face. Dr. Smith remarks that two of the members of the society have died from getting in the mouth the secretions of patients on whom they had performed the operation of tracheotomy. Sitting near the right side of the patient, he dips the electrode into the saleratus water to wet the cotton; then placing it on the tongue, he holds the knife by its metallic handle in the left hand, while he lays the right hand very gently on the sponge of the positive electrode. The current will now pass through the operator, and he can regulate the power of the current to the ability of the patient to bear it without pain. If he wants a stronger current, he can grasp the sponge a little tighter. As soon as the patient becomes accustomed to the current on the tongue, the operator may pass it (the electrode) gently up to the side of either tonsil. Watching a good opportunity, he can now pass it back to the posterior wall of the pharynx, and even down to the epiglottis. This last position is likely to make the patient cough, and will in some instances, make him vomit. In either case, mucus in large quantities will be thrown out, and it will become necessary to remove the electrode; but before this is done, the current should be broken by raising the

right hand from the sponge electrode. The cotton on the electrode should be secured by winding a little thread around it, and the operator should be careful not to let the electrode touch the teeth, as that will cause pain. If the current passing through the operator be too weak, he may bring the positive sponge up and touch the handle of the knife. The electrode must be removed occasionally, to give the patient a chance to breathe, to spit, etc. It is not necessary to use a strong current. The electrode for the nose can often be passed back as far as the posterior wall of the pharynx.—[*London Medical Record*.

## Editorial.

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### ARTICLE XIV.

The forty-second volume of the JOURNAL begins with a brighter out-look for its future usefulness, than it has hitherto enjoyed. We hope that our friends will not forget the request we made in our last number, and that they will not hesitate to co-operate to make all our numbers replete with interesting items culled from their practice.

In this number we present the first of a series of lectures on fractures and dislocations, by Prof. Jno. T. Hodgen, and in the near future a similar series on operative procedures in obstetrics and gynæcology by Prof. G. M. B. Maughs, will be begun.

The JOURNAL will be continually improved in excellence, and will continue in the future, as it has in the past, be the leading medical monthly of the Mississippi Valley.

This begins the thirty-ninth year of its existence, and of its usefulness, and we would like to see it not only more useful, but indispensable to all who take it. We hope our readers will aid us and with many wishes for a prosperous year, we begin once more with renewed ardor, the task of endeavoring to please our patrons.

## Book Reviews.

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### ARTICLE XV.

**NOTICE.**—In order to secure reviews of books it will be necessary to send duplicate copies of the same. Authors sending reprints will please remit them in triplicate in order to obtain notice in this department. In all cases, where *single* copies of books or pamphlets are sent, a mere acknowledgement of their receipt only will be made.

**THE PHYSICIAN'S DAILY POCKET RECORD.** Comprising a Visiting List, many useful Memoranda, Tables, etc. By S. W. BUTLER, M. D. (Philadelphia: Published at the Office of the *Medical and Surgical Reporter*, 1882.)

This visiting list is a good one as the number of years it has lived attests. It contains first, a perpetual almanac, next a posological table and then the various matters usually found in these lists. It is designed for thirty-two patients per week, and is perpetual, the dates being left blank.

The cover closes with a spring, and altogether it is one of the neatest and handsomest lists which we have received this far. It is small, durable and cheap, and we can heartily recommend it.

**TRANSACTIONS OF THE AMERICAN GYNÆCOLOGICAL SOCIETY.** Volume V. for the year 1880, 8vo. pp. 170. (Boston: Houghton, Mifflin & Co., 1881.)

This, the fifth volume of Gynæcological Translations, is fully up to the high standard which has been established in the former volumes. The papers are all valuable and interesting, and by men whose standing in gynecology is good. The President, Dr. J. Marion Sims, in his annual address, asks that the Society be more liberal and broad in its views as far as the constitution and by-laws are concerned.

The indications for normal ovariectomy are discussed in a paper by the reviver of the operation, Dr. Robt. Battey, in a paper entitled: What is the Proper Field for Battey's Operation?

Two cases of anterior displacement of the ovary simulating inguinal hernia, and in which Battey's operation was performed, is the subject of one of Dr. Engelman's papers, the other being Posture in Labor: an Ethnological Study. This is a very long

and exhaustive paper, and withal interesting, the discussion which follows being no less so.

There are eleven other papers of great value and which all elicited discussion. Then follows indices. There is among them an index to the gynæcological and obstetrical literature of all countries for 1879, an index to obstetric and gynæcological journals and one to obstetric and gynæcological societies.

The book is handsomely gotten up, and does infinite credit to the publishers. It is gotten up in a European style, the leaves not being cut.

- A PRACTICAL TREATISE ON IMPOTENCE, STERILITY, and Allied Disorders of the Male Sexual Organs. By SAMUEL W. GROSS, A. M., M. D. 8vo. pp. 174, with sixteen illustrations. (Philadelphia: Henry C. Lea's, Son & Co., 1881. St. Louis: St. Louis Book and News Co.)

The work is divided into four chapters, the first devoted to impotence, the second to sterility, the third to spermatorrhœa and the fourth to prostatorrhœa. The author recognizes atonic, psychical, symptomatic and organic impotence, discussing each variety clearly. The author says that he never saw but one case of psychical impotence in his practice, and yet it would not seem to be such a rare affection.

Sterility, he finds due to either of three causes: azoospermism, aspermatism or misemission. The causes of these conditions are pointed out, as also the proper treatment to be pursued.

The diagnosis, treatment and classification of the subjects considered are given in clear and terse language, and he insists that in sterility the husband is at fault almost once in every six cases. He also wishes to point out one error—that impotence and spermatorrhœa are commonly described as functional diseases the testicles, whilst he has found them, for the most part, dependant upon reflex disturbances of the genito-spinal centre induced or maintained by lesions of the prostatic part of the urethra.

The mechanical work is excellent, the type being large and clear and the binding neat. On the whole, this is a brochure which will well repay an attentive perusal of it.

TRANSACTIONS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Third Series, Vol. V., pp. 800, cxi—141. (Philadelphia: Printed for the College and for sale by Lindsay and Blakiston, 1881.)

This is a very neatly gotten up volume, containing the papers read before the College from Aug., 1879, to July, 1881. Memoirs of Drs. Geo. B. Wood, Isaac Hays, John Marshall Paul,



J. A. Meigs, T. L. Leavitt, John Neill, and Isaac Ray precede the transactions proper.

Foot-Binding in China, by Robert P. Harris, is the first paper, occupying seventeen pages and being a clear exposé historical, descriptive and anatomical of this wide-spread custom in China.

The next paper is a very interesting account of a case in which heart-clot occurred as a consequence of uræmic convulsion and tumors in the heart, by Arthur V. Meigs.

The reports of the committee on meteorology and epidemics for the years 1878 and 1879, are interesting despite the formidable array of dry figures and tables. A case of general hyperostosis, by James H. Hutchinson, is illustrated with two fine heliotypes, and is one of unusual interest. The treatment was experimental, consisting of ten grains of oxide of potassium thrice daily. The patient improved slightly.

Prof. Da Costa, contributes a valuable paper on starvation fever.

Foot-Binding in Ningpo, China is a supplement to his paper on foot-binding by Robert P. Harris. J. Ewing Mears reports a case of diabetes mellitus in which double cataract existed. The patient died three days subsequent to an operation of extraction. The autopsy throw no light on the connection between the diabetes and the cataract; it would seem from other indications observed by the author, that there was no such connection as is sometimes observed.

The concluding paper is by Geo. Hamilton, upon vivisection, with reference to its restriction by legislative action, and is a thoughtfully considered paper.

**MEDICAL COMMUNICATIONS of the Massachusetts Medical Society, Volume XII., No. 7, 1881. 8vo. pp. 473-671, 191-254. (Boston : printed by David Clap & Son, 1881.)**

The first article, numbered 21, is an address by J. C. Collins Warren, on Medical Societies : their organization and the nature of their work. It is an estimable work, dealing with many matters such as are *en rapport* with medical societies.

On June 7, 1881, the Society held a meeting in commemoration of its first centennial anniversary. On this occasion Samuel Abbott Green made a Centennial Address, which is a pleasing and entertaining history of the Massachusetts Medical Society.

Following this are the Proceedings of the Counsellors, the Annual Meeting held June 7, including a full account of the Dinner held, and which has already appeared in various journals.

The proceedings are printed in large, clear type, and when the various parts are bound together, will make a very handsome volume.

**THE MOTHER'S GUIDE IN THE MANAGEMENT OF INFANTS.** By JOHN M. KEATING M. D. 18mo. pp. 118 (Philadelphia: Henry C. Lea's Son & Co., 1881.)

This little volume is divided into three parts, the first devoted to the general management from birth to dentition, the second to the general management during dentition, and third to the management after early dentition. The first two are far the larger and more important parts, and the whole, as its name indicates, is rather intended for the laity than for the profession.

We would object to it, however, that it contains too little information in regard to treatment of various disorders considered, for the physician, and a little too much for the mother. We are decidedly opposed to putting sharp-edged tools in children's hands, and this is what our author does in deluding mothers with the belief that they are competent to treat their infants for such disorders as convulsions, croup, catarrhal diarrhoea etc. Of course he partly remedies this defect by giving the sound advice of procuring a physician and only having recourse to to drugs in his absence; still an awkward friend is a very inconvenient person to have about.

The author's dietetic rules are good in the main, and if carefully followed, of some value. He remarks very sensibly, that there is a certain experience which "cannot be learned from books; it cannot be learned from lectures; it can only come from a daily repetition of the duties of the nursery. No woman, however much she may read and study, can learn from it to hold a baby, or to wash a baby, or even, I may say, to dress or feed a baby." He furthermore advocates having a nurse who properly understands the care of infants.

Bottle-feeding and the choice of milk are considered at some length, as such subjects deserve. Altogether this is a handy and useful little book, which is well adapted to young mothers.

**A PRACTICAL TREATISE ON NASAL CATARRH.** By BEVERLY ROBINSON, A. M., M. D. (Paris) pp. 182. (New York: Wm. Wood & Co., 1880.)

In 1878, I stated to several gentlemen, who were discussing, in private, the most appropriate name for the American Laryngological Association, then in process of formation, that such advances in the study of the diseases of the nose would, in a few years be made, that the consideration of laryngitis would lose its rank in importance, and would be made to take, what I thought was its proper place, a secondary disease; and that in a very few years, those of the profession who were giving particular attention to laryngology, would see that every throat complaint, not specific or traumatic, was always preceded by an inflammation of the nasal and pharyngo-nasal cavities. Also, that all the

advances made in the treatment of laryngitis, would be made by those who took the diseases of the nasal passages into consideration while treating the throat.

The appearance of this work so soon after these remarks, as well as the ushering in of other treatises on the same subject, shows, in part, that my assertions were correct. In a few years, what I then said, will be agreed to by the whole profession.

I have read Dr. Robinson's book through carefully, as I do every new book on this and allied subjects, and have made many marginal notes. While it does not quite come up to the standard of my ideas in the hygiene and treatment of the nose, yet it is far, very far in advance of any work that I have seen come from the East. His preface is short, 12 lines, and merely states his intention to make his book contain "a succinct, though complete account of personal experience and convictions, and then, if possible, render it valuable as a practical guide to others."

THOS. F. RUMBOLD.

**A MANUAL OF DISEASES OF THE THROAT AND NOSE.** By F. H. BOSWORTH, A. M., M. D. 8vo. pp. 427 (New York: Wm. Wood & Co. 1881.)

In his preface he says: "The following pages are the result of an experience extending now over nearly ten years." His practice has been partially private, but mainly in the Bellevue Clinic for diseases of the throat. "I have endeavored to confine myself to my own personal experience, recording with candor and fidelity, both the method and measure of my success, and with the same candor, acknowledging the difficulties and disappointments which have attended the management of those diseases in the treatment of which I have failed of full success."

In his first chapter he describes the use of the laryngoscope, and the relative position of the physician to his patient. It is really remarkable that, in this work, as in almost every other work on the same subject, the patient examined, represents a gentleman. He is illustrated as being straddled by the examiner. The probable reason for not illustrating a lady patient as the one that is being straddled, may be on account of the well known modesty of the author, who would no doubt shrink from exhibiting in public, his method of disposing of his lower extremities while he was viewing a female's arytenoides.

This position of the physician is not only a very inelegant one, but a very inconvenient one. If our author's illustration on page 8 is true to nature, (and, judging from our acquaintance with his physiognomy, it looks as though he had been photographed while in the act of making an examination), his eyes are at least 24 inches from his patient's vocal cords. This is too great a distance for exact observation. If a physician, in examining a throat or nose, will sit at his patient's left, so that the

thighs of each will be side by side, then, when both turn slightly to the left, the faces of both will be opposite to each other, and within 10 or 12 inches. At this distance, an examination can be made with precision and with ease.

It is noticeable that he always applies the tongue depressor with his own hand, instead of allowing the patient to use it. The latter method is much pleasanter to the patient, as well as being more convenient to the physician. Even a slight pressure on a patient's tongue, if made by the physician, will, in a majority of instances, produce retching or contraction of the fauces and an elevation of the soft palate, which thwarts the end aimed by the use of the instrument; but if the patient has the tongue depressor entirely under his own control, there will be no dread or apprehension of any disagreeable sensation being made by the instrument, the muscles of the fauces and velum will be far more likely to remain quiet and passive.

His second chapter is upon the anatomy, physiology and inflammation of the mucous membrane. This, he says, he has compiled from Green's Pathology and Morbid Anatomy. It is presumed that he means Dr. T. Henry Green of London.

In his next chapter he treats of the methods of applying medicines to the mucous membrane. He first speaks of applications to the larynx, recommending the use of the probang, brush or sponge, saying that their application demands a special skill, only obtainable by practice. Further on he says "whether this [passing the probang into the larynx] was done by Dr. Horace Green, as claimed by him, has been called in question; certainly in our day no one would hardly dare attempt this manipulation without the use of the laryngeal mirror." Had the author been in the London Throat Hospital during the months of July and August of 1881, he would have seen applications made to the larynx (?) of every throat patient, without the tongue being drawn forward, or its being depressed, and without the aid of the pharyngeal reflector. This was done by an individual who had been connected for years with the institution.

In speaking of applications to the upper pharynx, he considers that the main obstacle to reaching this part with topical agents is the tendency on the part of the muscles to contract on the slightest provocation. To surmount this, he relies on educating the patient to a proper control of the part, failing this, he recommends the method of Dr. Wales of the U. S. Navy. This procedure consists in passing a cord through each nostril to the pharynx, and drawing it out through the mouth, when it is passed over the ear on each side and tied behind the head. That the author thinks well of this method, is proved from the fact that he has invented and illustrated a canula for passing the cord through the nasal passages. He thinks that this should always be resorted to when it will aid to the completeness of the diagnosis, or promote success. No doubt a patient who is seri-

ously alarmed about the condition of his head, may submit to this painful and needless operation for about three times, or at the most five times. After this experience he will have observed a new series of painful symptoms arising from the cutting effect of the cord on the velum; for no patient can completely contrall the action of the palatial muscles. The author continues, "Open access having thus been obtained to the upper pharynx, applications may be easily made by the probe, brush, sponge or spray." The practitioner who cannot so manage his patient, that the velum will remain pendent, so that even as great, if not greater opportunity will be afforded for making application, than can be done by these two strings, is simply so incompetant, that his attempted treatment is little short of an imposition on the patient.

He continues, "The use of the spray of course requires that the palate should be retracted or relaxed, while the other methods of application are available even if the palate is drawn up, the instrument being crowded through the contracted opening, though of course in this procedure more or less of the fluid is liable to be pressed out and trickle down the pharynx into the larynx." It is well known that it is impossible for the cavity to become completely closed by muscular contraction, without the mucous membrane being formed into folds, this being the case, it is impossible for the physician to apply a remedy to the whole of the surface while the contraction endures, as it would be to wash clean a clenched fist, by thrusting the probang between the closed fingers and the palm of the hand. If such a hand would be opened after such an attempted cleansing, it would be found that there would be streaks that were cleansed and streaks that were untouched, hence, untreated, and this untouched portion would form at least one-half of the whole surface.

In the chapter on taking colds, he gives Rosenthal's and Seitz's theories. He does not quite agree with either of them. This is one of the best chapters in the book. There can be no doubt that the author makes some very good points, points that will stand thorough investigation, and they may yet lead to the solution of this unsolved mystery. Indeed, upon the proper understanding of this subject will depend the further progress toward a proper treatment of the consequences of taking a cold. It seems impossible at present to form a theory that will fit every circumstance connected with the sometimes active, and sometimes passive manner in which a cold taken. In this same chapter he speaks of the prevention of colds and gives, in little over three pages, all of his suggestions as to the course to be pursued. A little too brief, for so important a subject. He makes a very true and very important suggestion in the treatment of a cold; it is that it should not be allowed to take its own course without treatment. His abortive treatment of cold is good, it consits of copious perspiration brought about by a decoction of hot tea taken at bedtime, this with the addition of

a foot bath, a moderate dose of Dover's powders, and a ten grain dose of quinine, has the desired effect.

In the treatment of chronic catarrhal pharyngitis, after cleansing the parts, he applied a solution of nitrate of silver. Of this agent he says: "We possess no remedy so efficient in chronic inflammation of the pharynx of a purely catarrhal character as nitrate of silver; and yet I know of no remedy that has been misused to such a mischievous extent as this." He thinks that it should never be applied, in a catarrhal affection, of a greater strength than gr. xx ad 3j and that even a v gr. or x gr. solution may be found more efficient. Other remedies that he considers valuable are chloride of zinc, sulphate of zinc, tannic acid, etc. He treats a cutefollicular pharyngitis by applying, with a sponge, or a probe wrapped with cotton, a xl gr. solution of nitrate of silver. In chronic follicular pharyngitis, he prefers a v. gr. solution of the bi-chloride of mercury. A little farther along he says that he knows nothing better than the actual cautery for affections that have existed for sometime; occasionally he makes free incision with the knife directly through the follicle and cauterises the cut surface with a solid stick of nitrate of silver. It is hard to understand how an inflammation can be reduced by such very irritating processes. He treats croupous pharyngitis by painting the location of the deposit of the membrane with a solution of nitrate of silver, grs. lx to the 3j. In the treatment of sub-acute tonsillitis he uses chlorate of potash, alum, borax, tannic acid and other astringents. In that of acute follicular tonsillitis, he uses tincture chloride of iron, chlorate of potash and nitrate of silver, the latter in a xx. gr. to a xl. gr. solution.

In a disease that he calls Atrophic or Dry Catarrh, he thinks the best results can be secured by the use of powders. He places *sanguinaria* at the head of the list of those that he recommends. As this remedy is very powerful in its action, causing a burning pain lasting for a long time, even in  $\frac{1}{4}$  the quantities that he recommends, it is difficult to see how he can expect to reduce inflammation by producing so severe an irritation. He speaks of fetid nasal catarrh, and immediately afterwards of *ozæna*, making two complaints of what is considered by many as one disease. For chronic catarrhal laryngitis he applies, by means of a cotton pellet, a solution of nitrate of silver from gr. iij ad xv to the 3j. In chronic catarrhal laryngitis of syphilis he uses of the bi-chloride of mercury in a ij gr. solution, or a v gr. to a x gr. solution of chloride of zinc; or a v gr. to a xv. gr. solution of nitrate of silver.

In hypertrophic nasal catarrh, he uses sulphate of zinc and nitrate of silver from gr. j ad. grs. ii. to the 3j water; he says that these solutions should be in such strength that they will cause no pain or irritation. This last condition would certainly reduce his weakest solution of silver to  $\frac{1}{4}$  of the strength what he recommends.

The questions may be asked, has he given us anything new in his mode of using nitrate of silver? Has not the great majority of authors, since the greatly abused Horace Green, recommended its use just as he has? Have they not stated that its successful employment was dependent upon as many conditions as he has named? And, has not almost every physician in the land, since Horace Green's time, been disappointed with the effects of its application? Not only is this disappointment due to the remedy itself but also to the method taken to apply it. The *sponge-probang* or the *brush* is an imperfect means of applying either a liquid or a powder. For instance, if a circumscribed spot in the pharyngo-nasal cavity or in the larynx is to be touched, it cannot be done without touching other parts also, because either passage, in its spasmodic closure, will instantly grasp the instrument and in this way apply the remaining medicated liquid or powder to every portion of the presenting folds. If the application is made so quickly that the instrument is taken out of the mouth before the contracting passage can grasp it, then a portion of the powder or liquid that was placed on the inflamed or ulcerated spot, will be applied to the healthy part of the membrane that comes in contact with this spot, during the closure of the passage caused by the contraction. In this way a healthy portion of the mucous membrane, that is pressed against the spot touched by the instrument, will receive an application of a remedy that it does not require, and which will be certain to injure it.

If the whole surface is to be treated, this also will be incompletely accomplished for the reason that as soon as the patient feels the contact of the instrument, instantaneous contraction of all the muscles surrounding either passage will ensue, thus completely closing it. This spasmodic closure will be only partially relaxed, while the patient is making expulsive efforts to eject the instrument or the medicament by retching or coughing or both combined. It is evident, under these circumstances, that it is only those parts of the mucous membrane that form the projecting folds, on closure of the fauces, which receive the force and application from the instrument. One might as well expect to wash the hand clean, by forcing a probang between the fingers and the palm when the hand is tightly closed. In this instance, and in that of the throat, the presenting ridges only are cleansed, leaving those portions of the surface that formed the creases between the folds, untouched, hence uncleansed, and those untouched portions, form at least one-half if not two thirds of the entire surface.

He greatly favors the Weber Nasal Douche, and thinks that it may be used with decided benefit. "We have every reason to suppose the entire diseased membrane is reached by remedies applied in this manner."

"Every reason," means that he has made the experiment on the cadaver, and saw that the entire diseased membrane was reached

by this means. Has he made this experiment? He does not say so! It means also that at least one-half of the patients that employ the Weber douche, have remedies applied to the entire diseased membranes of their nasal cavities and are cured thereby, and, that he knows this by actual experiment and inspection on at least a dozen patients. Has he made this experiment and inspection? He does not say so! Experiments of this kind have been made a great many times, and they proved that neither he or any one else have *one reason* to suppose that this kind of a douche reaches the entire diseased surface. Positive assertions unsupported by facts, are grievous faults in an author.

Dr. Jarvis' wire snare ecraseur is prominently brought forward. It deserves favorable mention by every author on this subject.

He has grouped together, in a tabulated form, four diseases of the larynx that to some extent, resemble each other. This is a very good method of studying the four distinct diseases named. They are: Superficial ulcers of syphilis; deep ulcers of syphilis; laryngeal phthisis and carcinoma of the larynx.

In the chapter on Tumors of the Larynx, he has quite a number of old familiar illustrations of instruments, some of which have been in our books on throat diseases for a score of years; several of the forceps could not be made to reach nearer than a half of an inch of the vocal cords, even after long education of the patient to tolerate instruments in the throat.

He treats tracheotomy very fully. In this chapter we see the illustration of an instrument, that on page 387, is called LaBorde's tracheal dilator, and the very same instrument is illustrated on page 24, and is called Elsberg's nasal speculum. His last chapter contains the very short, but valuable history of 23 cases of extirpation of the larynx. He completes his book with an appendix containing the formulæ of cleansing, astringent, stimulating, sanative, altertive and disinfecting solutions; in the same place he speaks of snuffs, powders, inhalations and cough mixtures.

We are sorry to say, at the close of this lengthy review, that taking into consideration the opportunities of the author, he has not introduced more original matter. Were it not that he speaks more fully and definitely on diseases of the nose than has formerly been done by a majority authors preceding him, his book would be but little more than a compilation.

THOS. F. RUMBOLD.



## Books and Pamphlets Received.

### ARTICLE XVI.

Anatomical Studies upon Brains of Criminals. A Contribution to Anthropology, Medicine, Jurisprudence and Psychology. By Moriz Benedikt. Translated from the German. By E. S. Fowler, M. D., 8vo. pp., 185. (New York: Wm. Wood & Co., 1881. St. Louis: St. Louis Book & News Co.)

Coulson on the Diseases of the Bladder and Prostate Gland. Sixth Edition Revised by Walter I. Coulson, F. R. C. S. 8vo., pp., 393. (New York: William Wood & Co., 1881. St. Louis: St. Louis Book & News Co.) July No. Wood's Library of Standard Medical Authors.

A Treatise on Food and Dietetics, Physiologically and Therapeutically Considered. By F. W. Pavy, M. D., F. R. S. Second Edition, 8vo. pp. 402. (New York: William Wood & Co., 1881. St. Louis: St. Louis Book & News Co.) Oct. No. Wood's Library of Standard Medical Authors.

Supplement to Ziemssen's Cyclopædia of the Practice of Medicine. Edited by George L. Peabody, M. D. 8vo. pp. 844. (New York: William Wood & Co. 1881. St. Louis: St. Louis Book & News Co.)

Transactions of the Michigan State Medical Society for the Year 1881. No. 1, Vol. VIII. 8vo. pp. 107. (Lansing: 1881).

Annual Address delivered before the American Academy of Medicine, at New York, Sept. 20, 1881. By Edward T. Caswell, A. M., M. D. Published by order of the Academy.

Pasteur and Jenner. An Example and a Warning. By J. J. Garth Williamson. Through Dr. C. Spinzig.

A new Gynæcological Table. By W. A. B. Sellman, M. D.

A Handbook of Uterine Therapeutics and of Diseases of Women. By Edward John Tilt, M. D. Fourth Edition. 8 vo. pp. 328. (New York: William Wood & Co. 1881; St. Louis: St. Louis Book & News Co.) Nov. No. of Wood's Library of Standard Medical Authors.

**Primary Epithelioma of Larynx below Vocal Cords.—Unique Case.—Bilateral Paralysis of Laryngeal Abductors.—Death.** By D. Bryson Delevan, M. D. Reprint.

**Insanity in Relation to Law, with some Reflections on the Case of Guiteau.** By C. H. Hughes, M. D. (Reprint from the *Medical and Surgical Reporter*, Nov. 26, 1881.)

**The Nurse and Mother.** A manual for the guidance of monthly nurses and mothers. Comprising instructions in regards to pregnancy and preparation for child-brith, with minute directions as to care during confinement, and for the management and feeding of infants. By Walter Coles, M. D, 8vo. p p. 153. (St. Louis: J. H. Chambers & Co. 1882.)

**A Treatise on the Diseases of Infancy and Childhood.** By J. Lewis Smith, M. D. Fifth Edition thoroughly revised, with illustrations. 8vo. p p. 836. (Phila. H. C. Lea's son & Co. 1881. St. Louis: Hugh R. Hildreth Printing Co.)

**Essentials of the Principles and Practice of Medicine. A Hand-book for Students and Practitioners.** By Henry Hartsorne, A. M., M. D. Fifth Edition, thoroughly revised and improved with 144 illustrations. 12 m o. p p. 609. (Phila: Henry C. Lea's son & Co. 1881. St. Louis: Hugh R. Hildreth Printing Co.)

**The Science and Art of Midwifery,** By William Thompson Lusk, A. M., M. D. with numerous illustrations. 8vo. p p. 687. (New York: D. Appleton & Co. 1882. St. Louis Hugh R. Hildreth Printing Co.)

**A Text-Book of Physiology.** By M. Foster, A. M., M. D., F. R. S. Second American from the Third and Revised English Edition. With Extensive Notes and Additions By Edward T. Reichert M. D. with 259 illustrations. 12 mo. p p. 698 (Phila. Henry C. Lea's son & Co. 1881. St. Louis: Hugh R. Hildreth Printing Co.)

**The Therapeutics of Gynæcology and Obstetrics; comprising the Medical, Dietetic and Hygiedic Treatment of Diseases of Women.** Second edition, thoroughly rovised and enlarged. Edited by Wm. B. Atkinson, A. M., M. D. 8vo. pp. 671. (Phila.: D. G. Brinton, 1881. St. Louis. Hugh C. Hildreth Printing Co.)

[Jan.,

## News Items.

### ARTICLE XVII.

**OPHTHALMOLOGY: MIDDLEMORE FUND PRIZE ESSAY.**—The interest on the fund of £500 given in trust to the British Medical Association by Mr. Richard Middlemore, of Birmingham, to found a prize for the best essay on Ophthalmology, having accumulated for three years, the Committee of Council now offer, in accordance with the terms of the trust deed, a prize of £50 for the best essay on the Scientific and Practical Value of Improvements in Ophthalmology Medicine and Surgery made or published during the past three years. The successful essay will be the property of the Association. Essays must be in English or accompanied by an English translation, and forwarded under cover, with a sealed envelope bearing the motto of the essay, and containing the name and address of the author, addressed to the General Secretary of the British Medical Association, 161 A, Strand, London, and must be in his hands on or before May 31st, 1882. —*British Medical Journal*.

*The Australasian Medical Gazette*, No. 1. Vol. 1., has just arrived, and it is with pleasure that we place it upon our exchange list. It is a monthly publication of 16 pages, published by L. Bruck of Sydney, New South Wales. It is well printed and edited, and gotten up in the style of the *British Medical Journal*. We wish it all the success it can achieve at the antipodes.

**PROF. L. ELSBERG.**—The Trustees of Dartmouth College have elected Dr. Louis Elsberg of New York, Professor of laryngology and diseases of the throat in the Dartmouth Medical College. Dr. Elsberg has resigned the professorship which he has heretofore held in the medical department of the University of the city of New York. We congratulate Dartmouth College on the acquisition it has made in securing the services of Dr. Elsberg, as one of its faculty.

**FOREIGN BODIES IN BLADDER.**—A published list of foreign bodies introduced into the bladder (of both sexes) includes the following: 78 portions of catheters and lithotrites, 82 needles, pins, or tags, 7 bone or ivory needles, 6 ear-picks, 3 ivory whistles, 1 ivory spindle, 1 ivory stiletto handle, 15 leaden balls, 3 small keys, 8 metallic fragments of various kinds, 12 bones or splinters of bone, 12 pieces of pebble or china, 6 pen-holders 15 needle-cases, 12 pieces of tobacco pipes, 4 pieces of glass tubing, etc.—[*Med. Med. Jour.*]

**DR. DAVID. FOULIS.**—One of the most brilliant young surgeons of Scotland, recently fell a martyr to his duty. This was Dr. David Foulis of Glasgow. It was chiefly as a specialist in diseases of the throat that Dr. Foulis had made his mark. He achieved a European reputation by his performance of the operation of extirpation of the larynx, an operation which he had repeated with equal success. Recently he had occasion to perform tracheotomy in two cases of virulent diphtheria; from these cases he caught the disease, and died after a few days' illness.—[*Med. and Surg. Reporter.*]

**COHN ON THE EYES OF MEDICAL STUDENTS.**—Dr Cohn(*Med. Jahrb. d. K. K. Gesell. d. Aerzte z. Wien.*, 1881) says that fourteen years ago he found that 53 per cent. of the Catholic theological students, 55 per cent. of the law students, 56 per cent. of the medical students, 67 per cent. of the Evangelical divinity students, and 68 per cent. of the philosophical students, were myopic. In the summer of 1880, 59 per cent. of the medical students, were myopic, 55 per cent. of the junior or non-clinical students, and 64 per cent. of the advanced or clinical, the longer studies of the latter being probably the cause of the higher percentage. In discussing the cause, Cohn says that the blame lies entirely in the methods of study. The lecture-halls are badly lighted, the benches and desks so arranged as to make writing most uncomfortable and difficult, the type of the text-books is too small, and the lines too long (straining accommodation when the eye passes from the ends to the middle), as well as too closely printed. He recommends that the light should fall fully on every spot in the hall; that the benches should be 45 centimètres (17.7 inches) high, and 40 centimètres (15.8 inches) broad, while the desk should be 70–75 centimètres (about 29.5 inches) high, and 35 centimètres (13.8 inches) broad, to allow of easy writing. The type,

he says, should be 1.5 millimètres (.06 inch) in size—of small *n* for example—and 0.25 millimètres (.01 inch) in thickness of line; the intervals between the lines should be at least 2.5 millimètres (.1 inch) and the two lines should not exceed 100 millimètres (about 4 inches) from one side of the page to the other.—[*London Med. Record*.

CONCEPTION WITHOUT INTRODUCTION OF THE PENIS.—Dr. A. Lippel relates the case of a primipara to whom he was called who, it was stated, would not be delivered on account of a closure of the genitalia. Where the doctor expected to find a narrow passage, he found that at the acme of the pains the head descended to the labia where it was covered by a very tense membrane as by a bonnet. The waters had been gradually flowing away. A minute examination revealed in the center of the membrane an opening through which nothing larger than a pencil could be passed. A crucial incision was made from this as a center and in a minute thereafter a living child was born.

The case was one of a very firm hymen with an opening so small as to preclude the possibility of the entrance of the penis. The husband believed that the latter was entirely unnecessary, and was astonished when informed that coitus should be accomplished in another manner.—*Deutsche Medizinische Zeit.*—*Lancet and Clinic*.

Having assumed Editorial charge of the *Journal of Mental and Nervous Diseases*, previously edited by Drs. Jewell and Banister, of Chicago, I request that all exchanges be hereafter addressed to G. P. Putnam's Sons, 27 and 29 West 23d Street, New York.

WILLIAM J. MORTON, M. D.

This leaves the *Alienist and Neurologist*, the only periodical on nervous and mental diseases, published in the West. It is needless to say that we are advocates of Western physicians reading Western medical journals. Dr. Hughes' ability and enterprise have done much to bring about this change.

DR. J. MARION SIMS, we regret to learn, has deemed it prudent, for his health's sake, at the suggestion of his physician, Dr. Alfred L. Loomis, of New York, to return to Europe for the coming winter. He will remain in the southern portion of France for the time being; but those who may wish to correspond with him can do so by letters addressed to him to No. 12,

Place Vendôme, Paris, France. From a personal letter received from him only a few days ago, we rejoice to be able to state that his health has greatly improved, and that, with present indications, he will be able to resume active practice at his home in New York next spring. Let it be the prayer of all who recognize and appreciate genius and goodness of heart, that this great leader in the profession, may be fully restored to the full vigor of health. While not authorized to say as much, we are informed from another quarter, that the publication of his book has been prevented by his feeble health. If the profession should lose this publication, it would suffer an irreparable loss.—[*Va. Med. Monthly*.

Died, at his residence near Dublin, on Oct. 21, ALFRED MCCLINTOCK, M. D., LL. D., F. R. C. S. I., who is well known in this country as the author of "Clinical Memoirs on the Diseases of Women," and the editor of Snellie's Midwifery for the New Sydenham Society.

Also, at Paris, October 27, Professor JEAN BAPTISTE BOUILLAUD. Born in 1795, Bouillaud was a young and earnest student when the discovery of auscultation by Laennec gave him the means of making the discovery which will always be connected with his name—the relationship between rheumatism and cardiac disease. He was the author of the word *endocarditis*, and gave an excellent description of the anatomical changes which accompany that disease. In 1831, he obtained, by open competition, the chair of Clinical Medicine at La Charité, where he was an ardent teacher of the doctrine of Broussais, that all diseases were inflammations, and required treatment by bleeding. In 1832, he was returned to the Assembly by his native town, Angoulême, and after the revolution of '48, he was promoted to the post of Dean of the Faculty. He was a member of the Institute and of the Academy of Sciences.—[*Medical News*.

NIGHT-CALLS.—The *New York Medical Record* mentions that a physician is suing, at Shelbyville, Ind., for a divorce from his wife on the ground of cruel and inhuman treatment. Having a large practice, he is often called out at night. His wife, being jealous, refused to believe that all his absences from home were professional, and demanded that he should stay in of nights. He said that his patients would not stand neglect. Then she

adopted the plan of taking poison whenever he had a night-call, thus compelling him to remain and doctor her. She swallowed a deadly drug in this way several times, and her life was saved with difficulty. The husband claims that such conduct is a just cause for divorce.—[*Louisville Med. News*.

DR. BEN J. BALDWIN has been elected House Surgeon to the Manhattan Eye and Ear Hospital in New York. His abilities and his experience in the general practice of medicine peculiarly fit him for the study of ophthalmology.—[*Medical Herald*.

A TOM CAT STYPTIC is the term applied by some journalist to the following treatment: A woman on a southern plantation was bleeding to death from the nose. The doctor had no ordinary expedient, but seeing a cat in the house, he had its head chopped off. Then he secured a section of the intestine, cleaned it, tied one end and thrust it through the nostril, and lastly distended the gut by injecting water, and tied it near the nose. The bleeding was immediately stopped.—[*Pacific Med. and Surg. Journal*.

A FERTILE MULE.—A great zoological rarity is now on view at the Jardin d'Acclimatation, Paris. It is an African female mule, named Catherine. In 1874, this animal, together with a Barbary stallion, Caïd, and their offspring, Constantine, were about to be sent to the Vienna Exhibition, when they were all three purchased for the Gardens in Paris. Since then, Catherine has given birth to an offspring (Hippone), by a horse, in 1874; to two others (Salem and Othman), the sire being an ass, in 1875 and 1878; and quite recently, she has produced a fifth (Kroumir), the issue of the same horse as her first two offsprings. It is very interesting to compare together the members of this family, unique in origin. The fact of the mule being fertile positively disproves the Arab proverb: *N'har t'ouled el brain entsa oul redjet oulo entsa*: "When the mule produces offspring, women will become men, and men will become women." Salem and Othman are regularly used for the cars on the miniature tramway which unites Port Maillot to the Garden of Acclimatation.—[*Lancet and Clinic*.

TREATMENT OF ECZEMA BY MUSLIN IMBUED WITH OINTMENT.—Unna (Berl. Klin. Woch. No. 35, 1880) recommends a new method of applying ointments. Unstarched muslin is

soaked in the melted ointment, by which it becomes saturated. When dry, it is cut into pieces, as required, and when applied, it is kept in position by a bandage.—[*London Med. Record*.

According to Dr. Foot, of Dublin, there is nothing more than a little dexterity required to pass a catheter (say 10) into the larynx, a treatment which is now meeting with favor in œdema glottidis and croup.—[*Md. Med. Jour*.

LONGEVITY IN EUROPE.—M. De Solaville analyzes in the *Revue Scientifique* the results of recent European census by ages, and the register of deaths also by ages. If we strike a mean of the census from 1869 to 1872, we find that Europe (exclusive of Russia, Turkey, and some small Southern states) possessed in 1870 a mean population of 242, 940, 376, classed as follows from the point of view of advanced ages: 17, 313, 715 of more than 60 years; 79, 859 of more than 90; and 3, 108 of more than 100 years, i. e., 1 inhabitant in 12 of more than 60, 1 in 2,669 of more than 90, and 1 in 62, 503 of more than 100. Women, M. Solaville finds, are more numerous in the extreme old age than men, and the difference increases with age. Thus at 60 years the advantage is with the women in the proportion of 7 per cent., at 90 and above it rises to 45, and with centenarians to 60 per 100. It is in France that we find the greatest relative number of inhabitants at the age of 60 and upwards; but it is not so for centenarians, of which France has less than all other states of Europe except Belgium, Denmark and Switzerland. From a calculation of deaths, by ages, the result is reached that to the total deaths, those at the age of 90 and upwards bore the following proportions to the countries named, and arranged according to the decreasing order of importance: Great Britain 9. 73; Sweden, 7. 39; France, 6. 58; Belgium, 6. 07; Switzerland, 6. 00; Holland, 4. 47; Italy, 3. 76; Bavaria, 3. 42; Prussia, 3. 06; Austria, 2. 69. The result is in accordance with that we know of the mean age of the deceased in the same countries.—[*Oil and Drug News*.

A CENTENARIAN.—A writer in the *Lancet* reports that a man named Micheal Morgan, born in Alerkhill, has reached the advanced age of one hundred and seven years. He remembers well the battle of Ballinahinct which was fought in 1798. He follows the profession of mendicant, and walks three miles every



Saturday on a begging expedition. His sight and hearing are good considering his age. His memory is also good, but is soon tired out by any attempts to cross-examine him in verifying his history. He walks half bent and suffers from general muscular tremor; but the fact that he can take long walks and expose himself to the most severe weather without discomfort is evidence of a remarkable preservation of physical power.

**QUININE INUNCTION.**—According to Dr. Jules Simon (*Gaz. des. Hôp.*), when quinine is used externally, in the form of an ointment with equal parts of lard, it is not discovered in the urine until after the third day in children above two years of age, and somewhat earlier in those who are younger.—[*Louisville Med. News.*]

We have received the initial number of the *Detroit Clinic*, a weekly of sixteen pages. Edited by Dr. H. O. Walker and O. W. Owen, together with Drs. Theo. A. McGraw, E. L. Shurley, N. W. Webber and T. N. Reynolds. The subscription price is one dollar per annum, and the publisher, Geo. S. Davis of Detroit. The objects of this new venture are among other things to furnish clinical articles and to "establish medical education on a higher basis." We hope that the publication may be successful in its aim, and not lack moral and financial support.

**THE FIRST POST-MORTEM IN AMERICA.**—The earliest recorded examination, made in 1670, is mentioned in a manuscript order of the Council of Lord Baltimore.

**THE FILARIA A NOCTURNAL PARASITE.**—It has lately been discovered that this curious parasite during the day disappears from the blood, to re-appear at night.

**AMERICAN PUBLIC HEALTH ASSOCIATION.**—The ninth annual session of the American Public Health Association was held November 29th., at Savannah, Ga. There was a large attendance. The meeting was called to order by the President, Dr. Charles B. White. The following papers were read at the morning session: "The Contagious Diseases of Domestic Animals," by Dr. Ezra M. Hunt, of New Jersey; "Disease Among Texas Cattle," a continuation of the report made to the associa-

tion at the New Orleans meeting, December 1880, by Dr. J. R. Smith, United States Army; "A Report of the Examination of Hogs at the New Orleans Abattoir during the summer of 1881," by the New Orleans Sanitary Auxiliary Association; "Trichina Syiralis," by Dr. J. M. Partridge, of Indiana; "Trichina Spiralis in American and German Hogs," by Dr. F. S. Billings, veterinary surgeon, of Massachusetts. At the afternoon session, the following were read: "The Kankakee, a Sanitary Problem in Indiana," by Prof. J. L. Campbell, of Indiana; "The Comparative Vital Movements of the White and Colored Races in the United States," Dr. S. S. Herrick, of Louisiana; "The Disposal of the Dead," Dr. W. H. Curtiss, of Illinois; "The Relation of Alimentation to Infantile Development and Diseases," Dr. T. C. Duncan, of Illinois. In the evening a public reception was given at the Temple. The meeting was presided over by the Mayor. An address of welcome was delivered on the part of the city authorities, by the Hon. George A. Mercer, and on behalf of the Georgia Medical Society of Savannah, by Dr. R. J. Nunn. President White read his annual address. The association was afterward entertained at the residence of Dr. L. A. Tallegaut.—[*Med. Record*.

Dr. Theophilus Parvin is to be appointed to the chair of obstetrics and medical and surgical diseases of women in Louisville University.

The intelligent compositor made Dr. Spinzig say *chronology* for *chorology* in lines 4 and 25, page 614 of Vol. XLI of the JOURNAL; but accidents will happen sometimes.

FOR SALE.—Medical and surgical books and instruments. My entire outfit will be sold very cheap. Reason for selling, rapidly failing health. A rare chance for a young physician. The vacancy made in practice by my illness is fully occupied.

For further particular write to

E. L. SHACKELTON, M. D.  
Auburn, Placer Co., California.

The Madison County Medical Society will have its next meeting on the last Tuesday in January 1882, in the Masonic Hall in Alton, Ills., exercises to commence at 10 A. M. A cordial invitation is extended to visiting brethren.

S. E. BUCKNELL, Sec'y.

It is a well-known fact that many physicians after graduating in the west go to the eastern cities and also to the continent for the purpose of obtaining a more practical and thorough education than that given in the ordinary medical colleges. Some of the faculty of the Missouri Medical College and a few specialists of the city have formed a school for physicians only, where clinical experience in all the various branches of medicine and surgery will be given. Free use will be made of the manikin and of the cadaver in this course, which will commence on February 20, and continue six weeks.

G. P. Putnam's Sons announce for early publication the following works:

A treatise on the Science and Practice of Medicine. By Dr. A. B. Palmer, Professor of practice of medicine in the University of Michigan.

Clinical Studies of Diseases of Children. By Mary Putnam Jacobi, M. D.

The Student's Manual of Diseases of the Skin. By L. D. Bulkley, M. D.

The Student's Manual of Diseases of the Nerves. By E. C. Seguin, M. D.

Aids to Diagnosis. Part III.—What to ask. By J. Milner Fothergill, M. D., M. R. C. P.

Sensation and Pain. By Dr. C. Fayette Taylor. 16mo. cloth.

Suicide. Studies on its Philosophy, Causes and Prevention. By James J. O'Dea, M. D. 12mo, cloth.

The Thirteenth Annual Meeting of the Iowa State Medical Society will take place at Des Moines, Iowa, Jan. 25, 26 and 27, 1882, and a very interesting time is promised to all who may attend. The meeting will be one of general interest, owing to the papers that will be read and to the standing of their authors in the profession. A large, cheerful and commodious hall will be provided for the meetings.

T. J. Caldwell the president, of Odel, will make the Annual Address, and the following papers are promised:

- 1.—Are the Poor Houses of Iowa proper places for the Care of the Incurable Insane?—M. H. Walpes, M. D., Dubuque.
- 2.—The Plea of Insanity.—A. Reynolds, M. D., Clinton.

3.—Primary Indications of Insanity.—Mark Ranney, M. D., Mt. Pleasant.

4.—The Duty of the State to her Feeble-Minded Children.—O. W. Archbald, M. D., Glenwood.

5.—Pyelitis occurring during the Puerperal State.—L. C. Swift, M. D., Des Moines.

6.—The Diseases Incident to Military Prisons, and the Influences by which they are Modified.—Wm. Watson, M. D., Dubuque.

7.—Operative Procedures in Corneal Lesions.—C. M. Hobby, M. D., Iowa City.

8.—Medical Ethics and Medical Advertising.—H. C. Bulis, M. D., Decorah.

9.—Life; what is it?—J. B. Gorrell, M. D., Newton.

10.—Hæmorrhagic Diathesis.—B. F. Kierulff, M. D., Marshalltown.

11.—The Disappointments of Country Physicians in the Practice of Gynecology.—J. Williamson, M. D., Ottumwa.

12.—Inversion of the Uterus—a Case.—J. A. Blanchard, M. D., Des Moines.

13.—Microscopy.—J. J. M. Angear, M. D., Ft. Madison.

14.—Gun-shot Wound—a Case.—J. W. Gustine, M. D., Carroll.

15.—Antiseptic Surgery.—R. A. Patchen, M. D., Des Moines.

16.—Sanitary Matters.—R. J. Farquharson, M. D., Des Moines.

17.—Management of the Newly-born Child.—G. W. Beggs, M. D., Sioux City.

18.—Local Treatment of the Mucous Membrane of the Air Passages.—E. H. Hazen, M. D., Davenport.

19.—Report on Necrology.—A. W. McClure, M. D., Mt. Pleasant, (Chairman.)

Any member having any case of special interest to the profession is cordially invited to present it.

## METEOROLOGICAL OBSERVATIONS.

By A. WISLIZENUS, M. D.

The following observations of daily temperature in St. Louis are made with a MAXIMUM and MINIMUM thermometer (of Green, N. Y.). The daily minimum occurs generally in night, the maximum at p. m. The monthly mean of the daily minima and maxima added and divided by two, gives quite a reliable mean of the monthly temperature.

THERMOMETER, FAHRENHEIT—NOV., 1881.

Day of Month.	Minimum.	Maximum.	Day of Month	Minimum.	Maximum.
1	47.0	69.5	18	35.5	38.5
2	49.0	49.0	19	26.0	29.0
3	36.0	48.0	20	21.0	33.0
4	38.5	64.0	21		
5	48.0	61.0	22	32.5	36.0
6	42.5	65.5	23	30.0	35.0
7	50.5	61.5	24	16.5	26.0
8	47.0	54.0	25	20.0	40.5
9	38.5	52.0	26	35.0	47.0
10	40.5	43.5	27	36.5	55.0
11	40.5	50.5	28	36.5	60.0
12	40.0	49.0	29	47.0	63.0
13	38.5	60.5	30	51.5	64.5
14	37.5	54.0	31		
15	37.0	43.0	Means	36.7	49.5
16	37.5	62.5	Monthly Mean	43.0	
17	55.0	68.5			

Quantity of rain, 5.33 inches.

## MORTALITY REPORT.—CITY OF ST. LOUIS.

FROM OCT., 9, 1881, TO OCT., 29, 1881, INCLUSIVE.

Small Pox..... 1	Childbirth..... 3	Convulsions & Trismus Neonatorum 36	Syphilis..... 0
Scarlatina..... 10	Inanition, Want of Breast Milk, etc. 13	Hydrocephalus and Tub. Meningitis. 2	Apoplexy..... 10
Pyæmia & Septicæ 1	Alcoholism..... 6	Meningitis & Encephalitis..... 20	Dis. fem. gen. org. 1
Erysipelas..... 1	Rheumatism & Gout 2	Other Diseases of the Brain and Nervous System 19	Surgical Operation 0
Diphtheria..... 18	Cancer and Malignant Tumor..... 12	Cirrhosis of Liver and Hepatitis..... 16	Premature Birth 0
Membran's Croup. 10	Phthisis & Tuberculosis, Pulmon 67	Enteritis, Peritonitis, and Gastritis..... 22	Deaths by Suicide 11
Whooping Cough. 3	Bronchitis..... 9	Bright's Disease and Nephritis..... 6	Deaths by Accident 2
Ovarian tumor..... 0	Senility..... 17	Other Diseases of Urinary Organs. 0	Congen Deor'ty 31
Measles..... 0	Pneumonia..... 15	Diabetes..... 0	Total Deaths from all Causes..... 626
Typhoid Fever..... 25	Heart Diseases..... 22		Total Zymotic Diseases..... 199
Cerebro Spinal Fev 1	Other Diseases of Respir'y Organs 15		Total Constitutional Diseases..... 145
Remittent, Intermittent, Typho-Malarial, Congestive & Simple Contin'd Fevers. 40	Heat Stroke..... 0		Total Local Diseases..... 191
Puerperal Fevers... 4	Marasmus—Tabes Mesenterica and Scrofula..... 57		Total Develop'tal Diseases..... 51
Diarrhoeal Disease's 64	Other Const. Dis 5		Deaths by Violence 0
Other Zymotic Diseases..... 2			

CHAS. W. FRANCIS, Health Commissioner.

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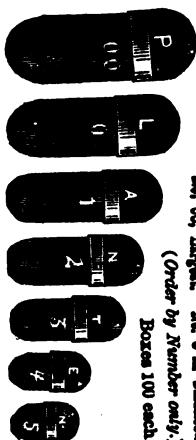
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The means of teaching now at the command of the Faculty are unsurpassed in the United States. Special attention is called to the opportunities presented for

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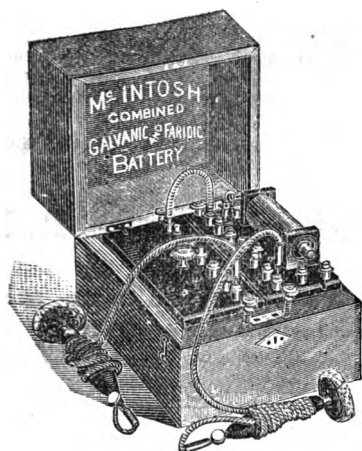
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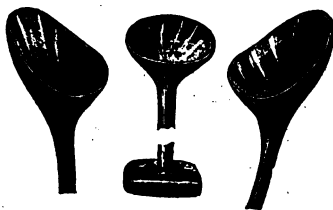
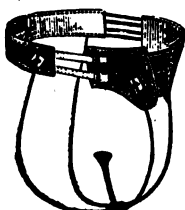
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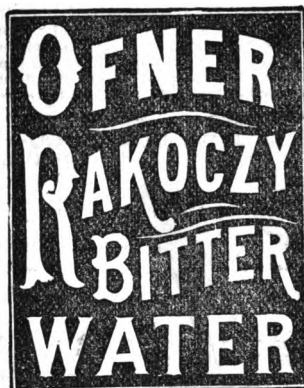
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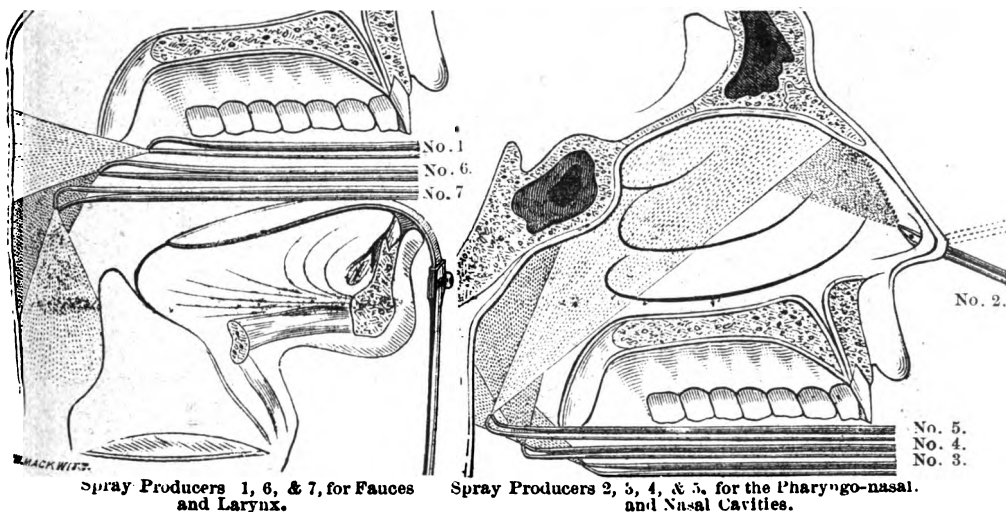
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Cheken (known also as Chekan and Chequen), was introduced to the profession of England through a report of results following its use in chronic bronchitis or winter cough by Wm. Murrell, M. D., M. R. C. P., Assistant Physician to the Royal Hospital for Diseases of the Chest, and Lecturer on Practical Physiology at the Westminster Hospital. Dr. Murrell's report is very favorable and he has supplemented it by private advices to us expressing great satisfaction with the drug in the affections in which he has employed it. He regards it as one of the most valuable introductions of late years and pronounces it a drug of very superior properties in the treatment of **chronic bronchitis**, acting in this affection both as an anodyne and exerting a favorable influence over the organic changes in the mucous membrane. It is certainly a remedy which merits a thorough trial at the hands of the profession of this country.

**SIERRA SALVIA.** ("MOUNTAIN SAGE.") *Artemisia Frigida*. Fluid extract of the herb. Dose one to two fluid-drachms. **Diaphoretic and diuretic.**

The success which has attended the administration of this drug in "Mountain fever" has suggested its employment in all febrile conditions attended with suppression of the secretions of the skin and kidneys. Its action in fever seems to be two-fold, acting directly on the nervous centre, thus inducing a direct lowering of the temperature, and facilitating the radiation of the heat through diaphoresis which it stimulates. Under its use, the kidneys are also aroused to activity, and the solid constituents of the urine proportionately increased. Therapeutic tests have corroborated the opinion formed of it on theoretical grounds.

**PERSEA.** (ALLIGATOR PEAR.) Fluid extract of the seeds. Dose 30 to 60 minims. This remedy is now for the first time presented to the profession of this country. It is introduced on the recommendation of Dr. Henry Froehling, of Baltimore, Maryland, who, while acting in the capacity of botanist and scientist to an exploring expedition in Southern Mexico, became familiar with the drug, both from reports of the natives and personal experience, as a remedy in **intercostal neuralgia**. The following extract from Dr. Froehling's report will give some conception of the nature of this remedy:

"A common experience among physicians is that some cases of intercostal neuralgia are very troublesome and obstinate, resisting almost every kind of treatment; particularly is this the case in malarial districts. In such cases I would recommend the fluid extract of Persea seed. In my own person and in every case in which I have employed it I have been highly gratified with the result. Those of my medical friends to whom I have given samples of the preparation warmly endorse my opinion of it as above and I cannot but believe that further trial of it will cause it to be regarded as a valuable addition to our list of medicines."

Dr. Froehling also mentions the fact that Persea has been employed with benefit in the expulsion of tapeworm.

**COCA.** (ERYTHROXYLON COCA.) The evidence in favor of Coca is to prove it a powerful nervous stimulant, through which property it retards waste of tissue, increases muscular strength and endurance and removes fatigue and languor, due to prolonged physical or mental effort. While indicated in all conditions presenting these symptoms it has an especial indication in the treatment of **the opium and alcohol habits**. In these deplorable conditions it has been found to possess extraordinary properties—relieving the sense of untold bodily and mental misery which follows the withdrawal of the accustomed stimulus, thus preventing a return to the parocetic, and affording an opportunity for building up the system by the administration of restorative tonics.

We prepare Fluid Extracts of all the above drugs.

PARKE, DAVIS & CO.,

MANUFACTURING CHEMISTS, DETROIT, MICH.